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The Impact of Training on the Attitudes of Mental Health Professionals Toward Borderline Personality Disorder

A Dissertation

Presented To

The Faculty of the School of Education

Counseling Psychology Program

In Partial Fulfillment

Of the Requirements for the Degree

Doctor of Psychology

By
Suzanne R. Fraser

San Francisco

May, 2001

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SIGNATURE PAGE

This dissertation, written under the direction of the candidate's dissertation committee and approved by the members of the committee, has been presented to and accepted by the Faculty of the School of Education in partial fulfillment of the requirements for the degree of Doctor of Psychology. The content and research methodologies presented in this work represent the work of the candidate alone.

Lyanne R Fraser — 5/10/01
Candidate — Date

Dissertation Committee

Terence Tollum — 5-23-01
Chairperson

Jennifer Ho — 5-22-01

Robert Burns — 5-20-01

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CHAPTER I

Introduction

The Research Problem

Individuals diagnosed with Borderline Personality Disorder (BPD) are presenting themselves for treatment at mental health facilities in ever-increasing numbers. Eleven percent (11%) of all psychiatric outpatients and 19% of psychiatric inpatients are estimated to meet the criteria for BPD (Linehan, 1993). Of all patients diagnosed with personality disorders, 33% of outpatient and 63% of inpatients meet criteria for BPD diagnosis (Widiger & Frances, 1989). The initial dysfunction of these individuals is extreme, and significant improvement can take several years (Carpenter, Gunderson & Strauss, 1977). Borderline individuals experience extreme problems with depression and affect management. They suffer severe impairment in their ability to maintain relationships. Patients with BPD are difficult to treat successfully and subsequently present major challenges to psychotherapists.

Increasing attention is being paid to the connection between traumatic childhood experiences and the later development of BPD (Laporte & Guttman, 1996). Most

recently, studies have shown that 70 to 79 percent of people with BPD report a history of serious abuse or psychological trauma (Santoro, 1997). BPD has been described as being a contributing factor in many of society's most vital social issues such as child abuse, the destruction of the nuclear family, substance abuse, and suicide.

The behavior pattern most frequently associated with borderline individuals is one of self-damaging acts and repeated suicide attempts. They are more likely to experience lethal suicidal behavior than patients in other diagnostic categories (Corbitt, Malone, Haas & Mann, 1996). Linehan (1993) suggests that self-injurious acts and suicidal behavior are the "specialty" of this disorder. Indications of the severity of this problem are reflected in: a) the documentation of intensive use of psychiatric services by BPD patients; b) frequent emergency room visits by individuals diagnosed with BPD, and c) their relatively high incidence of in-patient hospitalizations. However, as Linehan notes, self-injurious behavior is generally ignored as a focus of treatment by mental health clinicians.

Until recently, empirical studies that isolate attributes of effective treatment of BPD disorder have been

virtually nonexistent (Ellis, 1991). The lack of an effective treatment modality for BPD creates a dilemma for clinicians that are often left feeling inadequate and overwhelmed, as they search for a treatment that promises some relief. The etiology of borderline traits has yet to be clearly defined. Lack of information about the disorder and the insufficient training about effective approaches to treatment have created resistance and prejudice on the part of many clinicians toward treating borderline clients. For those clinicians who do work with borderline clients, uncertainty about which treatment approaches are most effective may increase the risk of borderline patients engaging in self-injurious or abusive behavior(s). Therapists involved in treating borderline individuals often experience feelings of intense frustration and helplessness. As a result, clinicians frequently feel anger toward borderline clients that is counterproductive to the therapeutic process needed to help alter the behavior and to alleviate the suffering of the borderline clients (Linehan, 1993; Millon, 1996).

Background and Need for Study

The diagnosis of BPD is becoming more commonplace. According to the DSM-IV (APA, 1995), the prevalence of BPD

is estimated to be about 2% of the general population. The current census estimate of the U.S. population is 281,421,906, which suggests that approximately 5.2 million Americans suffer from this disorder. Of all borderline patients, 70-75% have a history of self-injurious acts such as slashing their wrists or drug overdose attempts (Clarkin, Widiger, Frances, Hurt & Gilmore, 1983; Cowdry, Pickar, & Davis, 1985).

The magnitude of instability in the lives of borderline patients has contributed to the perception of BPD patients as "one of the most difficult populations to treat or manage effectively" (Farrell & Shaw, 1994, p. 72). Farrell and Shaw suggest that the size of the borderline population and lack of effectiveness of current treatment approaches have contributed to the difficult challenge being presented to clinicians faced with providing treatment.

The success or failure of therapeutic intervention can be the difference between life and death for a borderline patient. Approximately 1 out of 10 borderline individuals will be successful in committing suicide, usually following a series of attempts (Stone, 1989). The potential of patients meeting DSM criteria for diagnosis as

"borderline," to engage in self-injurious behavior is a serious concern. Stone conducted a follow-up study of BPD inpatients that were discharged from the hospital for a period of 10-23 years. This study revealed that patients exhibiting all 8 diagnostic criteria according to the DSM-III at the time of admission had a suicide rate of 36% compared to a rate of 7% for individuals meeting only 5-7 criteria for a diagnosis of BPD.

Millon (1996), a noted researcher of personality disorders, describes the increasing numbers of BPD patients as a "contemporary epidemic" (p. 167). He contends that the significantly increased incidence of BPD over the last three decades is a real phenomenon that warrants the attention of clinicians. In Millon's opinion, the increased incidence of BPD will continue as rapid and fundamental changes in Western culture perpetuate discordant life experiences in the family and reduce availability of stabilizing social customs and institutions.

At present, many clinicians lack a clear and accurate understanding of BPD. Lack of knowledge, coupled with insufficient information concerning effective treatment of the disorder, has contributed to the development of

negative attitudes toward these patients and subsequent reluctance among many professionals to treat individuals who suffer from this disorder. "The unrelenting crises and behavioral complexity of a borderline patient often overwhelm both the patient and the therapist" (Linehan, 1993, p. 165). The difficulty experienced by clinicians is reflected in the increasing use of pejorative language in professional literature when describing BPD. Such language, according to Linehan, maintains negative perceptions of borderline patients in the minds of clinicians attempting to deal with the problem. The rising emotional distance between clinician and patient, as well as the anger and frustration felt by those faced with the task of assisting borderline individuals, is bolstered by DSM-IV descriptions of borderline patients that characterize them as manipulative and needy (APA, 1995). The need for an accepting and validating stance on the part of the therapist is critically important when addressing the suicidal behavior that typifies the borderline patient. Linehan suggests that the implementation of effective treatment approaches such as dialectical behavior therapy and understanding of the pathogenesis of the BPD will: 1) help impact clinicians' attitudes toward the borderline

patient; 2) provide clinicians with knowledge regarding effective skills for treating the disorder; and subsequently, 3) increase the willingness of mental-health professionals to treat borderline patients.

Purpose of the Study. The purpose of this study is to evaluate the impact of training in Dialectical Behavior Therapy (DBT) on the negative attitudes held by mental health professionals toward individuals diagnosed with BPD. It is proposed that subjects trained in DBT will: 1) increase their knowledge about BPD, 2) alter their attitudes toward BPD clients, and 3) increase their willingness to treat borderline individuals. According to Linehan (1993), when clinicians understand that principles governing normal behavior are the same as those that govern borderline behavior, these professionals will respond with greater compassion and empathy toward the difficulties faced by their borderline clients. Linehan suggests that with information about an approach that is scientifically sound and nonjudgmental, clinicians' attitudes regarding treatment of BPD individuals will improve.

Significance of Study and Theoretical Rationale. Linehan's (1993) work with BPD has revealed that the quality of the therapeutic relationship is the only thing

that keeps suicidal patients alive. Many therapists who are involved in treating borderline individuals are ineffective and confused about treatment protocols (Ellis, 1991, Linehan, 1993). This confusion has created a reluctance to treat individuals with BPD. McIntosh (1988) has raised the question in her research as to how to eliminate this confusion and resistance. Despite these concerns there has been a paucity of information regarding effective methods to address the problem. Studies of the quality of the therapeutic relationship have focused on the beliefs of the patient, but have not examined the beliefs of the therapist.

Thus, research is needed that can help identify factors that contribute to the elimination of negative attitudes on the part of mental health professionals toward the treatment of BPD. Research of this type will identify the necessary elements of effective clinical training. This research will validate the need to focus on emotions as well as knowledge in addressing the attitudes and beliefs of clinicians (Rogers, 1980).

Research Question. The research question addressed in this study is: 1) Will a 4-hour workshop on the topic of Dialectical Behavior Therapy(DBT) improve subjects'

attitudes toward as well as their willingness to treat BPD clients?

Definition of Terms

Borderline Personality Disorder (BPD). The term itself has been used for many years by the psychoanalytic community to describe a group of patients that did not benefit from the practice of classical psychoanalysis and who did not seem to fit into either the "neurotic" or "psychotic" categories (Linehan). Over the years, the use of the term "borderline" has evolved to refer both to a "particular structure of personality organization and to an intermediate level of severity of personality functioning" (Linehan p.5).

The current criteria for BPD reflect a pattern of behavioral, emotional and cognitive instability and dysregulation" (Linehan, 1993). The reorganization of information about BDP is supported by the data collected by Stephen Hurt, John Clarkin and their colleagues (1991). Hurt et, al. found three clusters of criteria. These clusters included a) identity issues (feelings of emptiness, intolerance of being alone), b) an affective cluster (labile affect, unstable relationships, intense and inappropriate anger) and c) impulse cluster (self-damaging

acts and impulsivity). Cognitive dysregulation did not appear in the analysis, due to results being based on the DSM-III criteria (Linehan).

Diagnostic instruments for BPD include the DIB, developed by Gunderson in 1981 and revised by Zanarini in 1989 (Linehan, 1993). The criteria most widely used for diagnosis are those listed in the "Diagnostic and Statistical Manual," including the most recent version (DSM-IV). Self-report instruments are also available for the purpose of screening patients (Millon, 1996).

Dialectical Behavior Therapy. Dialectical Behavior therapy is a therapeutic approach developed by Linehan (1993) to address the problems associated with borderline personality disorder. According to Linehan the overriding and pervasive target of DBT is to "increase dialectical behavior patterns among borderline patients" (p. 120). Put simply, this means both enhancing dialectical patterns of thought and cognitive functioning and also helping patient to change their typically extreme behaviors into more balanced, integrative responses to the moment (p. 120).

Dialectics. A world view or philosophical position that form the basis for the therapeutic approach and relationship described by Linehan (1993). Dialectics as a

philosophy stresses inter-relatedness and wholeness. According to this philosophy, identity is relational and parts are only significant when viewed in relationship to the whole.

Dialectics recognizes that reality is not static, but comprised of internal opposing forces. Within each thing, or system, exists polarity (Linehan, 1993). Finally, the interconnected and oppositional nature of reality leads to a wholeness that is continuously in the process of change. It is the tension between good and bad that produces change. Change is the essential nature of life.

From the point of view of relationships, dialectics also refers to the use of persuasion within a relationship to produce change.

Attitude. An attitude is defined by Eagly and Chaiken (1993) as a psychological tendency that is expressed by the evaluation of a particular entity with some degree of either favor or disfavor. This evaluation may take the form of a cognitive, affective or behavior response.

CHAPTER II

Review of Literature

This section will present a systematic and critical review of the literature that addresses: a) a clinical definition of borderline personality disorder, b) etiology and prognosis issues, c) attitudes toward borderline personality disorder; and d) effective therapeutic approaches to treatment as they apply to borderline personality disorder.

Borderline Personality Disorder

The DSM-IV (APA, 1995) defines Borderline Personality Disorder as:

> A pervasive pattern of interpersonal relationships, self-image, affects and marked impulsive behavior beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following: 1) frantic efforts to avoid real or imagined abandonment; 2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; 3) identity disturbance; markedly and persistently unstable self-image or sense of self; 4) impulse behavior in at least two areas that are potentially self-damaging; 5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior; 6) affective instability due to a marked reactivity of mood; 7)chronic feelings of emptiness; 8) inappropriate, intense anger or difficulty controlling anger; and 9) transient, stress-related ideation or severe dissociative symptoms (p. 650).

The Harvard Medical School Mental Health Letter (1994) characterized the disorder as follows:

> The diagnosis of the disorder known as borderline personality is not highly reliable, and even the concept of personality presents difficulties. Researchers disagree about the boundaries between personality disorders and the distinction between healthy and disordered personalities... Even the definition of personality and classification of personality traits and types have been elusive...by comparison with other names for personality disorders...the term "borderline" itself is vague and uninformative. Some experts think it is applied too freely to any frustrating and intensely annoying patient who presents many problems of complicated symptoms...three-quarters of patients diagnosed as borderline are women...the causes of borderline personality have been sought almost everywhere, from hereditary brain malfunction to modern culture...but it is unclear how the influence of heredity works and how far it extends. (p. 5)

The formal concept of the term "Borderline Personality Disorder" is relatively new in the history of psychopathology. It was first introduced by Adolf Stern (1938) and applied to patients who did not seem to fit into either the "neurotic" or "psychotic" categories. Since that time, the term has been used to describe patients who did not fit into any other category. Each of the major schools of psychological theory has offered different explanations for the etiology of this disorder. Psychoanalytic, biological, eclectic, bio-social and cognitive theorists have each suggested different

definitions and recommended different types of treatment (Linehan, 1993).

Linehan (1993) suggests that the criteria for BPD needs to be reorganized to reflect major patterns in the areas of emotional, interpersonal, behavioral and cognitive and self instability and dysregulation. Interpersonal dysregulation is characterized by unstable, conflicted relationships and poor social skills; behavioral dysregulation is characterized by suicide threats and self-damaging behavior; and cognitive and self dysregulation are characterized by low self-esteem, feelings of emptiness and an unstable sense of self.

Behavior patterns common to BPD, as defined by Linehan (1993), can be characterized by six categories. She describes them as:

1. Emotional vulnerability: This is experienced as a high sensitivity to negative emotional stimuli, high emotional intensity and slow return to an emotional baseline;

2. Self-invalidation: Tendency to invalidate or fail to recognize one's own emotional responses, thoughts, beliefs and behaviors. Unrealistically high standards and expectations for self;

3. Unrelenting crisis: Pattern of frequent, stressful, negative environmental events, some caused by the individual's dysfunctional lifestyle, other by an inadequate social milieu and many by fate or chance;

4. Inhibited grieving: Tendency to inhibit and over-control negative emotional responses, especially those associated with grief or loss.

5. Active passivity: Tendency to passive interpersonal problem-solving style, involving a failure to engage actively in solving of own life problems: learned helplessness and hopelessness; and,

5. Apparent competence: Tendency for the individual to appear deceptively more competent than she actually is, usually due to a failure of competencies to generalize across expected moods, situations and time.

Etiology and Prognosis. Linehan's (1993) definition of BPD and treatment strategies is based on her biosocial theory of the disorder. From the biosocial perspective, the core dysfunction of BPD, namely emotion dysregulation, develops as a result of transactions between certain key biological and social-environmental factors. The critical biological factors are those that produce extreme emotional vulnerability, extreme sensitive and reactivity to

emotional stimuli and a slow return to baseline levels once there has been an arousal. Possible candidates have been exposed to genetic influences, intrauterine experiences or early trauma to the nervous system. The relevant social-environmental conditions are those that create an invalidating environment.

In fact, recent genetic research utilizing studies suggests that many of the personality disorders, including BPD, are powerfully influenced by genes (DeMott, 1999).

The behavioral patterns that are typical of BPD are viewed as attempts to regulate intense emotions or they are the outcome of unregulated and unstable emotionality. Suicidal behavior is often the only way that a borderline individual can conceive of ameliorating their emotional pain and obtaining assistance from the environment. The lack of capacity to regulate emotions in appropriate ways, to control impulsive behavior and to tolerate painful stimuli reduces the possibility of engaging in successful relationships. The compassionate understanding of these aspects of the behavior of borderline patients is crucial to understanding the concepts presented in the remaining sections of this literature review.

The question of the prognosis of individuals diagnosed with BPD is central to the development of a complete understanding on the part of clinicians. An overview of research regarding outcome studies is presented by Kreger and Mason (1998). They cite the following studies:

1. The McGlashan Chestnut Lodge study (1986) showed that 53 percent of patients were considered "recovered" and patients appeared to improve once they reached their 40's.

2. A New York State Psychiatric Institute Study (Stone, 1990) utilized the GAF scale to measure change in borderline patients. This study showed two-thirds of patients in their thirties and forties as "recovered" according to the GAF.

3. Studies by Stone (1990) and McGlashan (1986) identified certain factors associated with positive outcomes for treatment. Some of these factors were likableness, candor, superior intelligence, attractiveness and the alleviation of depression during treatment. Poor outcomes were linked to chronic substance abuse.

4. Kreger and Mason (1998) also found certain common threads in the reports of "recovered" borderline individuals. They identified threads or traits including a willingness to work through their emotional pain. Such

individuals chose not to utilize drugs or self-mutilation to resolve their painful emotions. Those who improved were also reported to have a sense of faith in themselves, others or a "higher power." They did not tend to blame their problems on others, but had a sense of their own identity in spite of borderline symptoms. Additionally, individuals diagnosed with BPD had access to an ongoing therapeutic relationship with clinicians who were reported to possess certain characteristics. These characteristics included: 1) not taking the actions of their borderline patients personally, 2) believing that recovery was possible, 3) genuinely caring about their patients, 4) being committed to their patients and 5) observing appropriate limits. Finally, positive outcomes were also attributed to the proper medication being received.

Attitudes Toward Borderline Personality Disorder

This section consists of 1) attitudes of Mental Health Professionals (MHP) toward individuals diagnosed with BPD and 2) the nature of attitudes and attitude change.

Attitudes of Mental Health Professionals Toward BPD

The existence of pejorative language in professional literature describing the behavior of BPD individuals has been found to be pervasive (Linehan, 1993; Millon, 1996;

McIntosh, 1988). For example, Linehan (1993) points out that the term "manipulative" is used in the DSM-IV (APA, 1994) to describe the behavior of BPD individuals. The term "manipulative" is an example of what Linehan describes as a pattern of negative descriptors applied to this category of patients. Linehan further defines manipulative as an attempt to influence another person by indirect, insidious or devious means. Such language, she argues, characterizes borderline individuals as chronic liars. Linehan goes on to describe other pejorative references from the DSM-IV such as the following: "... typically, this involves the shift from being a needy supplicant for help to being a righteous and vengeful victim" (p. 651). Linehan suggests that use of the term "needy" reflects the rising frustration, anger, and emotional distance felt by mental health professionals, as well as the limited resources available to clinicians trying to deal with problems associated with BPD.

Millon (1996), a noted expert in the field of personality disorders, suggests that the term "Borderline Personality Disorder" needs to be abandoned and a new term applied because of the negative connotations now associated with the descriptor.

McIntosh (1988) traced a 40-year history of controversy about the BPD. She found a description of 81 symptoms, 17 of which were found to be common to all borderlines. Of these 17 symptoms, only four could be identified as significantly more prevalent among hospitalized patients than other diagnostic categories. McIntosh also found in her review that ideas concerning the treatment of BPD were considered controversial. Additionally, she found that literature regarding BPD had a distinctly derogatory tone. She, like the present researcher, had repeatedly heard clinicians verbalize their discomfort with, dislike of, and contempt for borderline clients.

McIntosh (1988) proposed that there are a significant number of clinicians with negative attitudes towards this group of clients and recommended that studies examining the attitudes and beliefs of clinicians are needed to address an area of concern currently ignored by social work professionals. Her qualitative-descriptive study used a cross-sectional survey designed to determine the comfort level of clinicians that treat BPD. Scores on the scale ranged from 1-50 with higher scores representing greater degrees of discomfort. One hundred twenty six

questionnaires were returned and provided the basis for the study. More than 50% of the clinicians believed that "manipulation" and "anti-social" behavior were defining characteristics of BPD patients. About 43% felt that lying was also characteristic; fifty percent (50%) of respondents also expressed discomfort with treating BPD individuals. Comfort level scores ranged from 12 to 49, with a mean score of 29.6 and a standard deviation of 8.22. To test whether specific beliefs were related to negative attitudes toward BPD, t-tests examined the relationship between comfort level scores and the two belief categories. None of the beliefs showed significance with one exception. Therapists who agreed with the statement, 'the ways that clients with BPD relate to others represent fixed character traits' were less comfortable with BPD clients ($t=3.7$, $p< .003$, $df = 94$).

McIntosh (1988) stressed the need to determine the factors that contribute to therapist discomfort in order for BPD clients to receive adequate service from the profession. An additional suggestion was made for further investigation of factors that foster comfort and an improvement of attitudes in clinicians that treat BPD. The author identifies a connection between clinicians' positive

beliefs that their treatment of BPD clients will be successful and clinicians' degree of comfort with providing treatment.

The Nature of Attitudes and Attitude Change

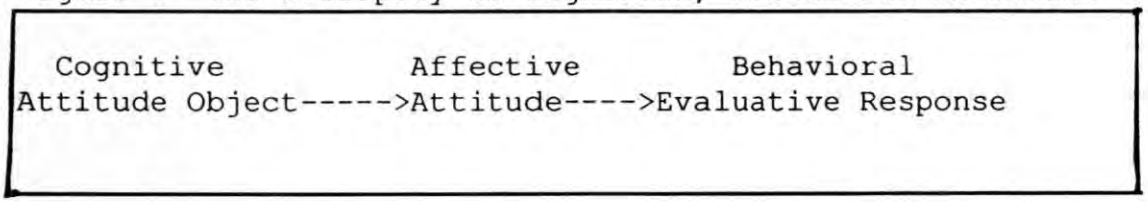
Definition of Attitude. An attitude is defined by Eagly and Chaiken (1993) as "a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor" (p. 1). According to the authors, the internal state or "psychological tendency" is a type of bias that predisposes an individual to respond with a negative or positive evaluation. This evaluation may take the form of a cognitive, affective or behavioral response. Eagly and Chaiken support the view that an attitude is a learned state that creates a tendency to respond in certain ways (Campbell, 1963). They believe that some attitudes can be relatively temporary and changeable, as opposed to an enduring state. Other theorists such as Allport (1935) and Doob (1947) also support this concept that attitudes are learned and thus, can be unlearned.

The definition offered by Eagly and Chaiken (1993) presumes that the evaluative state defined as "attitude" intervenes between certain types of stimuli and certain

classes of responding, such as approval, disapproval, liking or disliking, approach or avoidance.

Social scientists have concluded that responses can be divided into three categories: cognition, affect, and behavior (Katz & Stotland, 1959; Rosenberg & Hovland, 1960). "Cognition" refers to people's thoughts about the perceived object. "Affect" refers to feelings one has relative to the object. "Behavioral" refers to an individual's actions toward a perceived object (see Figure 1).

Figure 1 The interplay of cognition, affect and behavior.



Eagly and Chaiken (1993) also suggest that these three classes of response can be considered as antecedents to the development of an attitude. They suggest attitudes derive from a process of cognitive learning that is assumed to occur when people gain information about an attitude object and form beliefs through either direct or indirect experience. Thus, recipients of new information about an attitude object may be persuaded to form new beliefs about the object. In addition, Eagly and Chaiken cite examples

of studies supporting the claim that attitudes are based on emotional experiences.

In one classical conditioning model (Staats & Staats, 1958), an attitude object (conditioned stimulus) was paired with a stimulus that elicits an affective response (unconditioned stimulus), and eventually elicits an affective response as a result of repeated association. Zajonc (1980) suggests that "preferences" are based primarily on affective-type responses that are often immediate and not mediated by cognitive or evaluative processes about the attitude objects. Eagly and Chaiken conclude that the formation of attitudes can occur as a result of any one or combination of these processes. An attitude can also be described as "a schema or cognitive structures of organized prior knowledge, abstracted from experience, with specific instances" (Fiske & Linville, 1980, p. 543). Treating attitudes as schema aligns with the traditional understanding of an attitude as a "frame of reference."

The experience with attitude objects is assumed to lead people to associate them with certain attributes. These attributes are then stored as cognitive structures. Schema (Fiske & Linville, 1980) are useful in allowing

people to organize information that they encounter. Thus, attitudes serve the function of organizing and simplifying people's experiences, allowing them to "make sense" out of their experience. Positive attitudes assist people by maximizing the rewards they receive and by minimizing the negative experiences in their environment. People are then more likely to form favorable attitudes toward stimuli associated with satisfaction of needs, and unfavorable attitudes toward stimuli associated with punishment or frustration associated with need fulfillment. Katz (1990) states that attitudes also allow people to express their personal values and self-concept.

Theories of Attitude Change

Eagly and Chaiken (1993) reviewed three theories that attempt to explain attitude change. The first is known as Bayes' Theorem. According to this theory, beliefs should change in response to the introduction of new information or evidence about a subject or situation. This model suggests that persuasive messages and presentation of information that is relevant to the listener has the capacity to alter beliefs. The second theory is known as the Information Integration Theory. This theory suggests that attitudes and beliefs can be modified, and uses an

algebraic formula to calculate the process of attitude change. This formula suggests what determines the "weight" given to a message is its relevance, salience, reliability, and the quantity or amount of information provided. The third theory falls under the category of Process Theories. Process theories suggest that attitudes can be modified as people gain new information about the objects of their attitudes. The authors express the opinion that process theories are superior to information integration theories in the explanation of how beliefs can be changed.

McGuire (1969) suggests that the variables affecting the impact of persuasive communications act directly and indirectly to change attitudes through a "chain of responses" moving from attention to the message, to comprehension of its content, and finally, to the acceptance of its conclusions. Following this model, expert communicators have the ability to induce greater persuasion than non-expert sources, and provide greater incentive for the acceptance of their recommendations. The chain of responses must provide the listener with an incentive for adopting the conclusion of the message.

McGuire (1969) originally identified six different information-processing steps: presentation, attention,

comprehension, yielding, retention and behavior. According to this paradigm, the message recipient is first presented with the persuasive message. Once the message attracts attention, the arguments presented must be understood. Once understood, the message must be agreed with and then stored in the memory of the recipient. Once stored, the message can be retrieved and acted on some future point. McGuire later revised his model and suggested that immediate attitude change could occur as the product of a two step process involving: 1) a persuasive message, and 2) the receiving of and yielding to the message. This process, McGuire argued, was facilitated by the presentation of "good" news or a desirable statement in such a way that the receptivity of the listener would be greatly and quickly enhanced relative to the entire message to be presented. McGuire's studies confirmed that participants who first read a desirable statement followed by an undesirable statement showed more agreement with all statements, as compared with participants who were given the information in the reverse order.

Another theory of attitude change is known as the Cognitive Response Model. According to this model, people actively relate information contained in persuasive

messages to their existing feelings and beliefs about the topic being presented. For messages that elicit favorable thinking, enhanced thought processes should increase the occurrence of persuasion. This model asserts that cognition resulting from responses to persuasive messages are what determines the degree of attitude change (Greenwald, 1968; Petty, Ostrom, & Brock, 1981).

The Elaboration Likelihood Model of Persuasion (Petty & Cacioppo, 1986b) suggests that alternative peripheral mechanisms account for persuasion when the conditions for message-related thinking are not met. Theories that emphasize the mediational importance of argument-based thinking are considered "central route" theories (p. 306). Theories that specify psychological mechanisms are referred to as "peripheral" perspectives (p. 306). To summarize, this model postulates: a) people are motivated to hold correct attitudes; b) variables that affect motivation or ability to process a message can enhance or reduce argument scrutiny; c) as argument scrutiny is increased, peripheral cues become less important determinants of persuasion; d) attitude changes that result from central-route processing show greater resistance of time; and e) greater prediction

behavior than attitude changes that result mostly from peripheral cues.

Attitude studies have shown that operant conditioning of attitudes is possible if a verbal reinforcer then follows the expression of the desired attitude. If we accept Doob's (1947) definition of attitude as a "learned, implicit, anticipatory response," (p. 394) then conditioning might very well occur automatically, without the organism's conscious awareness, and without a deliberate, cognitive process. Staats (1993) was the first to recognize the relevance of classical conditioning principals as they applied to attitude. His studies showed that when a positive phrase was paired with a stimulus it produced a positive response to the stimuli on the part of the listener.

Carl Hovland, Irving Janis and Harold Kelley (1953) conducted significant research on the role of reinforcement at Yale University. These researchers emphasized the role of incentives and drive-reducing aspects of persuasive message content as mechanisms for reinforcing and creating acceptance of new beliefs and attitudes. They proposed that the process of attitude change must consider "Who says what to whom?" These researchers examined the role of

incentives and drive-reducing aspects of persuasive message content as mechanisms for reinforcing and creating acceptance of new beliefs and attitudes. Hoveland et al. (1953) demonstrated that incentives facilitate acceptance of messages from individuals who are perceived as highly respected. Incentives are also provided in an experience of self-approval that results from the feeling that one's beliefs and attitudes were correct, "rational," or congruent with important values. This study also demonstrated that "expert" sources of information can confer greater persuasion than non-expert sources because of the incentives provided by earning the "expert's" approval.

Theory of Cognitive Dissonance. The essence of Festinger's (1957) theory of cognitive dissonance is that the presence of dissonance between any number of elements in a cognitive system gives rise to a pressure to either reduce or eliminate it. The strength of this pressure is proportional to the degree of dissonance experienced. Eliminating dissonance requires the perceiver to change one or more cognitive elements. The reduction of dissonance might also take the form of adding consonant elements, or avoiding any information that might result in increases in

the magnitude of dissonance experienced. Cognitive dissonance theory is compatible with the drive-reduction notion that dissonance constitutes a state of negative arousal, the reduction of which is gratifying and/or reinforcing.

Functional Approaches to Attitudes and Attitude Change. Functional perspectives on attitude change contend that people hold or express attitudes for very different reasons. Thus, knowledge of the motivational basis for an attitude is the key to understanding how it might be changed. According to this school of thought, it is important to know the psychological functions that attitudes serve.

The work of Daniel Katz (1960) delineated the ways in which attitudes serve personality functions. Katz defined six functions that attitudes serve: 1) utilitarian, 2) knowledge, 3) externalization, 4) value-expressive, 5) social adjustment, and 6) compliance. Research suggests that a given attitude might serve to satisfy several of these needs simultaneously. Katz states further that the value-expressive function of attitudes acknowledges the need for self-expression and self-actualization. According to this function, attitudes are a means of expressing

personal values and are inherently gratifying because of the need to affirm one's own self-concept. Attitudes that also reflect the views of a person's reference group are considered to be a part of this value-expressive function. Attitudes that conform to one's reference group allow social relationships to be maintained and facilitate entry into desired relationships.

Attitudes provide a utilitarian function by facilitating the need for reinforcement versus the need to avoid aversive responses from one's environment. Thus, utilitarian attitudes might be instrumental in securing a positive outcome or in preventing an outcome that is negative. Attitudes related to knowledge provide a frame of reference for understanding the world and organizing a complex informational environment. Object-appraisal operates as part of this function by providing guidelines for evaluating objects or events. The ego-defensive or externalizing function is based on the psychoanalytical principles of denial, repression, and projection. These mechanisms are utilized by individuals to protect themselves from perceived threats. For example, an attitude of prejudice serves an externalizing function by defending oneself against their own negative attributes by

"projecting" negative characteristics onto an external group or individual.

The Impact of Behavior on Attitude Formation and Change. Janis and King (1954) suggest that an active improvisational process by which the role-player was asked to advocate for a position could create a self-persuasive effect. These experiments confirm that a role-player, when faced with positive incentives (e.g., anticipated positive consequences for assuming a particular position), would present improvised arguments in a manner that fostered open-minded cognitive exploration and adoption of the position they were advocating. Attitude change was thus enhanced by the absence of negative incentives about the consequences of adopting a recommended position. Later research established that the mere commitment to assume a position was sufficient to produce attitudinal adjustment. Actual engagement in an attitude-discrepant behavior was not a necessary condition for self-persuasion to occur.

The research and writing of Albert Bandura (1977) adds another dimension to theories of learning as they apply to the possibility of attitude change. According to Bandura, people are more likely to engage in or attempt certain behaviors when they believe they are capable of executing

those behaviors successfully, that is, when they have high self-efficacy. According to social learning theory, people's feelings of self-efficacy affect several aspects of their behavior, including their choice of activities, their effort and persistence and, ultimately, what they learn.

Social learning theory also suggests that people feel more confident, that is they have greater self-efficacy, when they have succeeded at the proposed task or at similar ones in the past (Bandura, 1977). To some extent, a learner's self-efficacy beliefs can be enhanced when others provide assurance that success is possible. Self-efficacy can also be enhanced by observing the successes or failures of other individuals, particularly those who seem to be similar.

Learned helplessness and optimism. Seligman's (1998) animal and human studies of learned helplessness found that continued failure to accomplish a task resulted in discontinuation of the task, in spite of reinforcement schedules. In his most recent studies, Seligman defined this behavior as pessimism, the attitude learned and adopted in response to failure and corresponding self-talk.

Seligman's (1998) most recent research also suggested that attitudes that were learned could also be unlearned. According to Seligman, pessimistic attitudes, with the correct intervention, could be changed to optimistic attitudes. His most recent study confirmed this theory. He surveyed the incoming freshman class at University of Pennsylvania, evaluating members for pessimistic qualities utilizing his Optimism Assessment Questionnaire. The pessimistic group was then involved in a 16-hour Learned Optimism workshop focusing on self-talk skills as well as behavioral skills, assertiveness training and stress-management skills. Posttest results on his Questionnaire confirmed that, as a result of his research that pessimistic attitudes could be altered and improved.

Therapeutic Approaches and Attitudes in the Treatment of BPD

Therapy process and outcome research has validated the importance of specific therapeutic attributes. These attributes are acceptance, positive regard and empathy. Rogers (1957) was the first to describe the importance of these qualities. Since that time, a large base of empirical investigation has given us a more refined

understanding of these concepts, as they are implemented in psychotherapy (Wright & Davis, 1994).

Looking to the "bottom line" (Wright & Davis, 1994) of successful outcome of psychotherapy, there is a strong consensus in the conclusion that the quality of the therapeutic relationship is central to change. Several authors have studied the therapeutic attributes that contribute to positive client change and growth: Rogers, 1957, 1980); Linehan, (1993); Egan, (1994); Patterson (1984, 1985); Deffenbacher, (1985) and Orlinsky, Grawe, and Parks (1994).

The theory that a solid therapeutic alliance is necessary for change to occur in the therapeutic process was first introduced and researched by Rogers (1957). Rogers is perhaps best known for his groundbreaking work defining attitudes that are necessary for clinicians to have in order for them to provide effective interventions to patients. Rogers did not believe that the clinician's special knowledge, theoretical background, or techniques determined the degree of his or her effectiveness. Rather, Rogers suggested that what was important was the extent to which the clinician possessed certain attitudes in the therapeutic relationship. Rogers reviewed his previous

work in 1980 and restated his original theory, that individuals have within themselves "vast resources for self-understanding and for altering their self-concepts, basic attitudes and self-directed behavior" (p. 115). He describes three "conditions" that must be present in a climate that is growth-promoting (p. 115). These conditions are described as follows:

1. Genuineness, realness or congruence. According to Rogers (1980), the more the therapist is himself or herself in the relationship, without a professional front or façade, the greater the likelihood that the client will change and grow in a constructive manner.

2. Acceptance, caring or prizing. Rogers describes this as "unconditional regard" (p. 116). The therapist is willing for the client to be themselves and to feel what they are feeling. When this occurs, the therapist prizes the client in a total rather than conditional way.

3. The third facilitative aspect of the relationship is empathetic understanding. This means that the therapist senses accurately the feelings and personal meanings that the client is experiencing. The therapist is also able to communicate this understanding to the client. Rogers describes empathy as one of the most powerful elements for

effecting changes in personality and behavior. The ability to truly empathize requires that the therapist be able to clarify not only the meanings that the client is aware of, but also those just below the level of awareness.

Rogers (1957) conducted numerous studies with an out-patient clinic population from his own counseling center and concluded that the more these attributes existed on the part of the therapist the more successful the outcome of therapy. This finding remained constant whether measures of attitudinal variables were based on the therapist's perceptions, ratings by impartial observers, or the client's perception of the relationship. According to Rogers, professionals who view clients as objects to be manipulated "for their own good," controlled, or directed in ways that satisfy the professional, will not have the capability to engage in a growth-promoting relationship with clients. Rogers expressed concern about the nature of the training programs for clinical psychologists, psychiatrists, and other helping professionals, believing these programs make it more difficult for professionals to "be themselves" as they are "submerged in a sea of diagnostic and psychodynamic evaluation" (p. 102).

According to Rogers (1957), it is necessary for a therapist to have their own feelings available, as well as an awareness and ability to communicate those feelings when appropriate. The more the therapist is able to listen and accept what is going on within him or herself, the more he or she is able to be congruent and facilitate the personal growth of the client. From his research, Rogers concluded that change in a client's personality is more likely to occur if he or she senses congruence on the part of the counselor. Rogers based this conclusion on studies of randomly selected hospitalized schizophrenic patients. Therapists who were most successful dealing with resistant patients were those who were able to react in a genuine, humane way and who exhibited their genuineness in their relationships with clients. The second essential quality a counselor must have is the ability to experience an accurate, empathic understanding of the client's private world and communicate elements of that understanding back to the client. Understanding of the client's inner world of personal meaning must be accurate and extended to the most bizarre, confused or inarticulate individual. Empathic understanding reaches beyond evaluating or analyzing the client, and communicates to the client that

his or her feelings are worth understanding. Once the client recognizes these elements of the therapeutic alliance, change on the part of the client is likely to occur.

The third condition that Rogers (1957) viewed as necessary for growth and change is a therapeutic attitude of warm, positive, acceptant regard for the client. The therapist must value the client as a person, regardless of his or her behavior at the moment. This acceptance requires a willingness on the part of the therapist to allow the client to "be" those feelings that are real to him or her at the moment. Rogers emphasizes that this acceptance is <u>not</u> a paternalistic, sentimental, or superficial response; rather, it shows a deep respect for the client, without any imposition of demands. Furthermore, the therapeutic relationship is most effective when positive regard for the client is unconditional, or without judgment. The attitudes described by Rogers must be communicated to the client in a way that can be understood from the client's perspective.

Rogers (1957) empirically tested his theories in studies that revealed that the counselor was the most significant factor in influencing the quality of the

therapeutic relationship. Specifically, client-counselor relationships in which the counselor showed a high level of congruence, empathy, and unconditional positive regard for the client showed constructive personality change and development, as indicated by positive changes on MMPI scales and a decrease in anxiety scores. When these qualities were absent from the therapeutic relationship, scores of the schizophrenic population reflected a negative change. Rogers also tested his theory with a group of schizophrenic clients who were not particularly interested in participating in therapy, and who did not hold a positive view of therapists. Even in these cases, Rogers found that the quality of the interpersonal encounter with the client was the most significant element in determining the effectiveness of the therapy.

Gerard Egan (1994) echoes many of Rogers' original concepts in his work. He described the need for a "client-centered working alliance" (p. 48) or pragmatic partnership between therapist and client. He emphasizes that different clients have different needs. Thus, the therapist's response should be tailored to the specific needs of the client. In addition, Egan identifies the qualities of competence and respect as necessary for effective therapy.

Egan defines respect as understanding and valuing diversity in each individual and the suspension of critical judgment. The need for genuineness on the part of the counselor is also viewed as essential. Egan contends the therapist must be able to check his or her attitudes, be certain that the client is receiving the therapist's total attention, and maintain an interested and open emotional and physical posture toward the client. Egan views empathy both as a way of being and as a communication skill. He suggests that judgments be set aside to allow the therapist to walk in the shoes of the client.

In an analysis of nine major review studies of relationship variables, Patterson (1984) concluded that the evidence in favor of the necessity of positive relationship conditions was as strong as any in the field of psychology. In subsequent work, Patterson (1985) describes the nature of the therapeutic relationship as central to the goals of helping the client. Patterson characterized the therapeutic relationship as being interpersonal, a relationship that requires establishment, development and fostering. In a similar manner, Deffenbacher (1985) defined activities of an effective therapist as:

lessening interpersonal anxiety in the relationship, increasing trust and building an interpersonal climate in which clients can openly discuss and work on their problems. Their clients need to perceive that they have a caring, positive, hopeful collaborator in understanding and making changes in their world (p. 262).

In a comprehensive review of the literature, Orlinsky, Grawe and Parks (1994) conclude that the most important determinant of outcome is the quality of patient participation in therapy. They found that the therapeutic relationship is a significant mediating link in the interaction between the process and outcome in therapy. Therapist warmth, empathy and a positive relationship and bond were the most strong associated with treatment outcome when the perception of the patient was considered. The role of therapeutic attributes was found to be critical, even in specific behavioral therapies. Studies of behavioral therapy revealed that patients who viewed their therapist as warm and empathetic were more willing to be involved in their treatment. This willingness ultimately was found to improve the outcome of the behavioral intervention. According to Orlinsky et al., these conclusions are based on hundreds of empirical results and

can be considered as scientific "facts" (p. 361). Therapists contribute to a successful relationship by engaging the client in a collaborative interaction with the use of empathy and affirmation (Orlinsky et al.).

Wright and Davis (1994) emphasize the complexity and importance of the therapy relationship. They conclude that the therapy relationship and therapeutic technique are interrelated aspects of a single process. Secondly, they affirm the quality of the patient's involvement as a crucial component of successful outcome in therapy. Third, they suggest that the evidence is convincing that the warmth and friendliness of the therapist plays a substantial role in creating a therapeutic bond, that in turn affects patient involvement. Fourth, they suggest that there must be an agreement between patient and therapist regarding issues such as control and affiliation. "Poor outcome has been associated with hostile, over-controlling interactions" (p. 29).

Wright and Davis (1994) suggest that the relationship between patient and therapist can be impaired significantly by negative beliefs or stereotypic attitudes. To facilitate and develop an emotional bond in therapy, the clinician must be alert *not only* to the patient's potential

negative attitudes but also to the possibilities of the clinician's own similar reactions. The authors suggest that clinicians cannot be free from conditioned negative emotional responses or "cognitive biases" (p. 37). Thus, efforts to fully engage patients in effective treatment relationships can be facilitated by the recognition and response to the many factors that can influence the therapeutic bond.

Linehan (1993) proposes that borderline individuals should be viewed with compassion in terms of the dialectical dilemmas that they experience. Linehan also suggests that the therapists attend to their own, corresponding dialectical dilemmas. The three dialectical dilemmas are summarized as: 1) emotional vulnerability vs. self-invalidation, 2) crisis vs. inhibited grief, and 3) apparent competence vs. active passivity. Linehan compares the emotional difficulties of the borderline patient to the suffering of a third-degree burn patient. According the Linehan the borderline has no emotional skin. Even the slightest touch can create immense suffering, yet life requires movement. In this situation, both the therapist and the patient must have the courage to encounter the pain that arises. She maintains that there are several

attributes that are necessary for a therapist to possess. These attributes include a positive regard for and attitude toward the BPD and the assumption that they are doing the best that they can.

Summary

This chapter reviewed literature in the areas of a) the definition of BPD, b) the nature of attitudes and attitude change and c) therapeutic approaches to effective treatment of Borderline Personality Disorder.

While the works of Millon (1976), Ellis (1991), and McIntosh (1988) refer to the existence of confusion about the etiology and definition of BPD, Linehan's work (1993) clearly defines the impact of this history on the effective treatment of this disorder. She supports the theory that misunderstanding of BPD has created negative attitudes toward the disorder among mental health professionals, thus limiting their effective response to the suffering of this group of individuals. She proposes that the use of pejorative language in clinical literature is evidence that this negative attitude toward BPD does indeed exist. McIntosh's research establishes a relationship between beliefs about the disorder and the willingness to treat. However, her study is based on a survey and did not attempt

to provide an intervention to alter the existing belief. McIntosh's study concludes with the suggestion that additional research is needed to address the existence of negative attitudes among clinicians toward BPD.

A review of theories based on studies published in the literature of social psychology established an understanding of the process involved in the formation of attitudes. Eagly and Chaiken (1993) offer several theories on the nature of attitude formation, a description of the purpose they serve as well as a description of the aspects of creating attitude change. The extensive studies conducted by Albert Bandura (1977) proposed that self-efficacy was a critical component if learning of any kind was to occur.

Additionally, an assumption of this study is that a positive attitude on the part of mental health clinicians toward their clients is critical. The importance of a particular therapeutic attitude is addressed in the review of the work of Rogers, (1980), Rogers and Stevens (1967), Linehan (1993), Egan (1994), Patterson (1984, 1985), Deffenbacher (1985), Orlinksy , Grawe and Parks (1994) and Wright and Davis (1994). Rogers' work is historically significant in that he established the need for a

therapeutic alliance that required the existence of a specific attitude on the part of therapists toward their clients in order to promote positive growth and change. Subsequent studies have expanded on the work of Rogers.

Wright and Davis (1994) have applied existing studies in the field specifically to the practice of cognitive-behavioral therapy. Orlinsky, Grawe and Parks (1994) have established a scientific basis for the consideration of the quality of the therapeutic relationship and its application to therapeutic outcome. Linehan's contribution has been to apply the concepts established and tested by Rogers to the specific issue of the treatment of Borderline Personality Disorder. Her study establishing the effectiveness of Dialectic Behavior Therapy is also particularly significant, involving year-long trials and a control group to measure the changes in suicidal behavior on the part of participants in her experimental group.

CHAPTER III

Methodology

This study examined the impact of a workshop designed to educate clinicians about a new conceptual model of the etiology of Borderline Personality Disorder and the corresponding methods of treatment. Linehan (1993) developed the model, known as Dialectical Behavior Therapy (DBT). The data for each subject was collected from two instruments, the demographic questionnaire and the Revised Attitude Assessment Questionnaire. All data was entered and statistical analysis conducted on the Statistical Package for the Social Sciences-Release 8.0 for Windows (SPSS).

Research Question

The research question addressed in this study was: Will a 4-hour workshop on the topic of Dialectical Behavior Therapy improve the participants' attitude toward and willingness to treat BPD clients?

Design

The study utilized a 2 x 3 pretest, control group design. Participants were assigned randomly to one of two

conditions: a treatment (workshop) group and a control group (wait-list). Three measures were obtained: 1) a pretest, 2) a posttest and 3) a follow-up administration of the Revised Attitude Assessment Questionnaire to participants before and after the intervention (treatment). The effects of the treatment were reflected in the amount of positive change from pre-to post-intervention assessment. A follow-up assessment was also administered to both the control and treatment groups 30 days following the intervention. The purpose of the follow-up assessment was to determine the durability of the intervention.

Sample

The Dialectical Behavior Therapy workshop was offered as an in-service training for Master's level certified professional counselors and social workers who are employed as staff members at a publicly funded mental health agency in Pinal County, Arizona on September 7, 1999. The total pool of workers within this agency is approximately 60. The total number of clinical staff members was randomly divided into an experimental group and a control group consisting of 30 members each (see Procedures section). Participants varied in their age, race, theoretical background, and length of time in practice, as well as

their experience with BPD patients. None of the participants had received any formal training involving Dialectical Behavior Therapy. A demographic information questionnaire included questions and categories addressing each of the variables was administered (see Appendix A). Information in this questionnaire also included each participant's theoretical background and orientation to therapy.

Demographic information. Table 3.1 shows the demographic variables of the subjects in both the control and treatment groups.

Table 3.1

Frequency and percentage for Demographics by Groups

	Treatment		Control	
Variable	*f*	%	*f*	%
Sex				
Male	8	27	8	27
Female	22	73	22	73
Age (years)				
Under 25	0	0	0	0
25-30	4	13	4	13
31-35	10	30	10	33
36-40	4	13	7	20
41-45	4	13	5	13
46-50	4	13	4	13
51-60	3	10	5	13
over 60	0	0	0	0
Ethnicity				
Asian	1	1	0	0
African American	5	16	2	10
Hispanic	3	3	3	10
Caucasian	21	70	25	80
Years in Practice				
< 1 year	0	0	0	0
1-2	4	13	4	13
3-5	10	33	10	33
6-10	9	30	3	43
11-15	5	16	0	7
16-20	2	6	0	0
over 21 years	0	0	0	0
Feelings influenced by				
Client contact	19	63	21	70
Continuing Ed	1	3.5	0	0
Colleagues	9	30	9	30
Formal Ed	1	35	0	0
Knowledge gained by				
Client contact	8	17	0	15
Continuing ed	10	43	23	38
Colleagues	0	0	0	0
Formal Ed	12	40	7	47
Experience with BPD				
Yes	24	80	24	77
No	6	20	6	23
Currently Treating				
Yes	16	60	15	50
No	14	40	15	50
Treatment Orientation				
Brief,	10	30	12	40
Family systems	3	27	0	30
Cognitive/behavior	4	10	2	7
Eclectic	8	11	2	11

This sample was chosen because of exposure to BPD clients and the over-utilization of the resources by such client populations. Master's level clinicians are likely to have had minimal training in the effective treatment of BPD, but are often given maximum responsibility for their care. The tendency of staff members in public mental health facilities to misunderstand and mistreat BPD often results in the exacerbation of symptoms and an increase in resulting problems (Linehan, 1993).

The staffs of public mental health agencies regularly participate in mandatory in-service training. This allows for a sample of individuals who have experience with BPD, but who are not going to self-select their participation in the intervention (workshop), based on their level of interest.

Human Subjects Considerations

The workshop took place in a large conference room with sufficient seating, light and facilities. Subjects were given breaks during the four hour workshop. A consent form was reviewed with each subject (see Appendix G). Forms included a description of the study and its purpose, a description of what each subject would be asked to do and a statement regarding the voluntary nature of

participation. Reassurance was provided regarding the confidentiality of all data, contact information was provided for questions and a space for the signature of both the participant and the researcher was provided. Participation requirements were carefully reviewed prior to the beginning of the workshop. A debriefing was held for all workshop participants following the conclusion of the intervention and completion of the post-test questionnaire.

An initial explanation was also provided for all control group members. Control group members were provided with an opportunity to participate in the workshop at a later time.

Instrumentation

A revised version of the Attitude Assessment Questionnaire (McIntosh, 1998)(See Appendix D) was administered in this study. Revisions were made in order to adhere to DSM-IV criteria for borderline personality disorder and to simplify administration. This questionnaire is the only instrument of its kind created to specifically measure attitudes toward BPD.

The Revised Attitude Assessment Questionnaire is comprised of 16 items designed to measure attitudes toward

BPD. The following is a list of the questions included in the RAAQ questionnaire:

1. I believe treating clients with BPD could be rewarding
2. I prefer to work. with clients with BPD over those with most other disorders
3. I prefer to work with clients who have BPD
4. I feel fulfilled working with clients with BPD.
5. Working with clients with BPD is enjoyable.
6. I am comfortable working with BPD clients.
7. I find working with BPD clients a welcome challenge
8. If given a choice, I would accept BPD clients in my practice
9. Clients with BPD can improve with the use of intensive group therapy
10. One of the primary goals in treating BPD clients is to address suicidal and para-suicidal behavior
11. Clients with BPD have difficulty with impulse control.
12. Clients with BPD have a poor prognosis
13. The etiology of BPD is primarily bio-social.
14. Traditional forms of therapy rarely benefit BPD clients
15. Clients with BPD respond to an empathetic, but firm approach
16. Clients with BPD can benefit from a skills-training approach

The 16 items are a five-point Likert scale, ranging from 1)("strongly disagree") to 5 ("strongly agree"). Thus, higher scores on items 1-8 indicate greater degrees of willingness to treat BPD and a more positive attitude toward BPD clients. Likewise, higher scores on items 9-16 indicate greater knowledge about etiology and treatment of BPD.

Pilot testing. Because this instrument was designed for use specifically in this study, pilot testing was conducted prior to the study (Cone & Foster, 1993). Pilot testing was used to determine the face validity for the proposed test instrument. Ten pilot subjects took (Babbie,1999) the proposed version of the Revised Attitude Assessment Questionnaire. Subjects were chosen with characteristics that matched the target population but who did not qualify as subjects in the actual study (Cone & Foster, 1993).

Changes to the questionnaire were made in response to feedback regarding the readability of each of the questions as they pertained to the etiology and treatment of BPD (see Table 3.2) and to more accurately reflect the DSM-IV diagnostic requirements for borderline personality disorder.

The original questionnaire developed by McIntosh included an initial 10 questions to measure knowledge (See Appendix D). In the Revised Questionnaire, these questions were eliminated and incorporated in questions 9-16.

Table 3.2 summarizes the comparison between the original and revised Attitude Assessment Questionnaire questions.

Table 3.2

A Comparison of the Original and Revised AAQ Questions

Original Question	Revised Question
Question #11 I believe that treating clients with BPD could be very rewarding.	Question #1 I believe that treating clients with BPD can be rewarding
Question #13 Clients with BPD have an inability to control impulses	Question #11 Clients with BPD have difficulty with impulse control
Question # 4 I feel unfulfilled working with clients with BPD	Question #4 I feel fulfilled working with clients with BPD
Question #6 Treating a client with BPD me uncomfortable	Question #6 I am comfortable working with clients with BPD
Question #20 If given a choice, I would would not accept clients with BPD in my practice.	Question #8 If given a choice, I accept clients with BPD in my practice.
Question #21 Clients with BPD can improve greatly with individual group psychotherapy.	Question #9 Clients with BPD can improve with intensive group therapy
Question #22 The primary goal in treating clients with BPD is to promote acceptable behavior.	Question #10 One of the primary goals in treating BPD clients is to address suicidal behavior.

Procedures

In order to create two random groups, all staff members who are assigned to attend regularly scheduled agency in-service training were assigned a number. Members of the treatment group were randomly chosen from a pool of numbers. A member of the agency clerical staff designated by the director conducted the selection. The remaining staff in the number pool were placed on a waiting list for the next in-service training and placed in the control group. They were given the Revised Attitude Assessment Questionnaire to complete on the day of the workshop, but without the benefit of participation in the workshop on DBT.

Thirty days following the workshop, participants and control group members were given a follow-up questionnaire to complete at their workplace.

Treatment

The treatment that was administered was a 4-hour workshop outlined in Appendix F. The workshop was led by a therapist trained in DBT. The workshop leader was not aware of the hypothesis of the experiment. The goal of the workshop was to introduce participants to the research results and philosophy of Dr. Marcia Linehan.

Session 1 of the workshop began with introductions and a chance for the participants to discuss their prior experience with borderline clients. Linehan's (1993) biosocial theory regarding the development of the disorder was presented in order to provide participants with a clear understanding of the etiology of the disorder. This portion of the workshop included the following information:

1. The definition of BPD as being "emotional dysregulation."
2. The connection between "emotional dysregulation" and invalidating environments
3. Explanation of the characteristics of emotion dysregulation
4. Characteristic of invalidating environments
5. Consequences of invalidating environments

A lecture/discussion was followed by a video of Linehan summarizing the information previously given and utilizing live discussions with her clients.

The final portion of Session 1 of the workshop involved the participants' completion of a Behavioral Chain Analysis (See Appendix E) of a situation involving their own behavior. The purpose of this exercise is to give

participants a hands on experience with Dialectical Behavior Training. A break was held following the initial session of 2 hours.

Session II of the workshop focused on the application of Linehan's theory in working with borderline patients. The lecture focused on the use of skills training to address life skills deficits and the issue of motivation. The targets for treatment were clarified and defined in order to promote the concept that the problems of this disorder can be effectively "managed."

A second video by Linehan was presented with examples of treatment applications with her own clients and information regarding the results of her research project on reducing suicidal behavior.

The problem of para-suicidal behavior was defined as the key issue in the treatment of BPD as a context for the subsequent role-play. Participants observed the presenting therapist using DBT strategies during a mock therapy session where the focus was suicidal feelings. Participants were then invited to participate in a brief role-play of a phone call from a suicidal borderline client and to attempt to utilize DBT strategies.

The workshop closed with a discussion of how participants felt about their experience and any final questions prior to the final administration of the Revised Attitude Assessment Questionnaire. Participants verbally reported that the workshop had been a positive learning experience.

Data Analysis

The effects of treatment were measured on the dependent variable of attitudes toward BPD individuals as reflected in the RAAQ score.

Descriptive statistics were reported for subjects in the sample in order to determine what effect exposure to Dialectical Behavior Therapy has on subjects' attitude toward and willingness to work with borderline patients. The data were analyzed through the use of a repeated measures ANOVA controlling for group (treatment or control). Group membership was controlled in order to identify the treatment's effectiveness and persistence over time.

The amount of change in the pretest/posttest and pretest/follow-up scores for the treatment and control groups was measured using a repeated measures general linear model analysis procedure. Using this method, the

scores are considered to reflect at least three factors (Runion, 1977): 1) the subjects' ability and/or proficiency on the criterion task, 2) the effects of the experimental variable, and 3) the random error due to a wide variety of different causes. There is little that can be done about random error. The effects of the experimental variable (the workshop) are the focus of the assessment. Probability levels that results occurred by chance were established at $p<.001$ as a result of the statistical analysis. This analysis was completed in order to ascertain the likelihood of committing a Type I error. Significance was evaluated using the standard criterion of $p<.05$.

As discussed above, these measures were constructed so as to be consistent. The sum of the subjects' responses to the items on the attitude measure were used. This sum is more easily interpretable than responses to factor scores or a factor-loading weighted scale. Repeated measures analysis was used because, unlike the frequent use of difference (end score minus beginning score) scores, repeated measures analyses use more information about the subjects' responses (Pike, 1992). Stone et al. (1996) also note that computing difference measures increases error

variance and thus diminishes the ability of statistical tests to find an effect. Residual scores resulting from regressing exit scores or entry scores are also widely used as a change assessment tool. These scores are only useful in examining differences between groups. Further, these residuals are not measures of change in itself, but instead are measures of that portion of the dependent variable not accounted for by the independent variable. Thus residual scores measure not only growth but any other variable omitted from the regression equation(s).

While repeated measures analyses, difference scores, and the use of regression residuals are all afflicted by problems of low reliability, it seems that repeated measures analysis is the most powerful technique available (Pike, 1992).

In addition, means, standard deviations, frequency distributions and percentages for the independent and dependent variables were computed. Cronbach's coefficient alphas were calculated to determine the internal consistency of the instrument.

The Pearson Product Moment Correlation Coefficent was used the investigate the relationships between the demographic variables and the dependent variables (test

scores).

Validity

Scale Analysis. The data were collected at three separate points using the same 16-item instrument. The results of each administration were factor analyzed to determine the underlying factor structure at the time of each administration.

The Cronbach's alpha at the pre-test administration was .33. The same set of analyses was performed for the one-month follow-up data. The Cronbach's alpha scores of the post-test were examined and found that the respective alphas were all in the acceptable range of .70 and higher. Specifically, the 16 attitude items had a Cronbach's alpha of .86. Cronbach's alphas were well within the traditional range for scale acceptability of .70 (Kerlinger, 1986; Nunnally, 1978).

The same set of analyses was performed for the one-month follow-up data. The results indicated that the attitude scales had a Cronbach's alpha of .86. Table 3.3 describes the pre-posttest and follow-up Cronbach's alphas.

Table 3.3

Cronbach's Coefficient Alphas for Pre, Posttest and Follow-Up Administration of the RAAQ

Scale	Cronbach's Alpha
Pretest	.33
Posttest	.86
Follow-Up	.86

Given the combination of these results, it seemed that a prudent and conservative test of the hypothesis could be had by performing a repeated measures analysis of the attitude scale.

Summary

This chapter included a review of the research design and the research questions and identified the relevant demographic characteristics of both the treatment and the control group. Human subjects considerations were addressed and described. This chapter also included a description of the instrument used to measure the variables of knowledge and attitude. The procedures involved with the completion of the study and collection of the data were identified. The chapter ended with a final review of the data analysis.

In the subsequent chapter, results will be presented the research question and a further analysis of the findings will be presented and summarized.

CHAPTER IV

Results and Analysis

The purpose of the study was to evaluate the impact of training in Dialectical Behavior Therapy (DBT) on the attitudes held by mental health professionals toward individuals diagnosed with BPD. It was proposed that subjects exposed to DBT would alter their attitudes toward BPD clients, including their willingness to treat individuals diagnosed with the disorder.

In order to test this hypothesis, a Revised Attitude Assessment Questionnaire (RAAQ) was administered to both a treatment and control group as a pre-test/post-test and follow-up measure of changes in attitudes and, consequently, willingness to treat. The questionnaire was designed to measure a positive change in each of the variables with an increase in the revised AAQ score from pre-test to post-test if the intervention was successful.

Data were collected from a total of 30 treatment subjects and 30 control subjects. All subjects were Master's Level mental health professionals employed by a community mental health agency in Arizona.

Statistical Analysis

In the following discussion the results of the study are presented in three sections: 1) descriptive statistics of the sample; 2) analysis of the research questions and 3) analysis of the findings.

Descriptive Statistics

Demographic data. The majority of participants in the treatment groups were middle-aged, Caucasian and female. Most participants had been in practice between 3 and 10 years, had developed feelings about BPD as a result of client contact and had gained knowledge through formal education. Most treatment subjects were currently treating BPD individuals and a slight plurality was using brief, solution-oriented therapy as their choice of therapeutic approaches.

Most subjects in the control group were between ages 31 and 35, Caucasian and female. Most participants in the control group had been in practice between 3 and 10 years, had developed feelings about BPD as a result of client contact and had gained knowledge about BPD through continuing education. Half of the control group were currently treating BPD. A plurality of the control group subjects was using brief, solution focused therapy as their

preferred approach to treatment.

In this design the individuals in both the experimental and control groups were chosen based on their work setting and degree (Master's level).

Analysis of Research Question

An analysis of the research questions utilizing a comparison of mean scores, an ANOVA and a frequency distribution comparison of scores for the treatment and control groups revealed that the treatment effect was significant with regard to the variable of attitudes toward BPD, based on the analysis of the pretest, posttest and follow-up test RAAQ. A detailed description of the data obtained follows.

Mean Scores

The RAAQ yielded an increase in the mean scores from pretest to posttest and upon 30 day follow-up for the treatment group receiving the four-hour workshop. No increase was found in the control group scores.

Table 4.1 shows the sums of the pretest posttest and follow-up scores for on the Revised Attitude Assessment Questionnaire as they relate to the participants' attitudes regarding BPD.

Table 4.1

Comparison of Pre-Posttest and Follow-up Mean Scores For Treatment and Control Groups

	Pretest	Posttest	Follow-Up
Treatment Group	45.07	57.90	58.00
Standard Dev.	3.45	2.17	2.26
Control Group	46.17	46.17	46.03
Standard Dev.	2.80	2.80	2.82

The direction of the scores among the pre-test, post-test, and follow-up administration shown in Table 4.1 makes it clear that these results are a result of the intervention and are significant ($p<.001$) in post-test and follow-up scores for the treatment group as compared to the pre-test scores for this group as they relate to knowledge.

The pre-test, post-test and follow-up scores for the control group do not show significant changes from the first administration of the instrument to the second (posttest) or to the third (follow-up).

Analysis of Variance

The tests of within subject effects were highly significant. Additionally, the time results were significant ($F=476.641$, $p<.001$; $F=486.726$, $df=2$). The eta-squared variable for both the main effects and the interaction term was high (.892 and .894 respectively). Nearly 90% of the variance was accounted for.

The time result and within-groups result represent the interaction between the repeated measures result from the administration of the RAAQ on three occasions to the same participants and the control/treatment group differences. The significance of the result scores indicates that the treatment group time measures increased to a greater extent than those of the control group. With respect to the between-subject effects, the group variable for differences between the treatment and control groups was found to be highly significant. The groups did not differ significantly on the pre-test scores. However, they did differ significantly on the post-test scores, and on the follow-up test scores.

Table 4.2 illustrates the variables for between-groups and within-groups effects.

Table 4.2

Two-Way Analysis of Variance Results for Pre-Posttest and Follow-Up Scores by Group

Source	ss	df	F	Eta-Square
		Between Group		
Group	2553.80	1	132.49	.70
Error	1117.98	1		
		Within Group		
Pre,Post & F/U	1642.68	2	476.64	.89
Time by Group	1200.00	2	486.73	.89
Error	199.89	2		

*Statistically significant at the .05 level

Frequency Distribution of Test Items. A frequency distribution of test scores was also conducted to further analyze the effects of the treatment. There were some observable trends in the test responses from the RAAQ. Table 4.3 shows the frequency of the five most common individual scores for the RAAQ. While this does not reflect the entire sample, it can be viewed as representative of the response of the participants.

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Summary of Findings.

Attitude results were evaluated as a combined scale and were confirmed at the same time. Data was not sufficient to support the analysis of two separate scales to measure knowledge and attitude. Statistically significant difference was found in participants' mean attitude scores on the RAAQ before and after the administration of a 4-hour workshop. This change was maintained in the 30-day administration. In contrast, there was no significant change reflected in the pre-test, post-test and follow-up scores of the control group. Further analysis revealed that tests of within subjects, between-subjects, time variable and interaction variable effects were significant.

Demographic analysis

In an attempt to better understand the data, the relationship between the demographic and the dependent variables scores was examined. An analysis was conducted of the relationships between ethnicity, age, gender, source of feelings about BPD, source of knowledge about BPD, currently treating BPD and experience treating BPD and the dependent variables of attitude/knowledge. Theoretical orientation to treatment was not evaluated, as

the majority of clinicians identified a similar theoretical orientation.

Upon examination of the relationship between ethnicity and the dependent variable scores, no significant relationships were found in either the treatment or control groups (See Appendix I, Table 4.5).

Further analyses revealed that there was no relationship between age and the dependent variable scores (See Appendix I, Table 4.6). Gender was also analyzed and was found to have no significant correlation with the dependent variables. This correlation is illustrated in Appendix I, Tables 4.7, 4.8. Additionally, the relationship between participants' sources of feelings about BPD and the dependent variable was analyzed. No relationship was found between sources of feelings about BPD and the dependent variables for either the treatment or control groups (see Appendix I, Tables 4.9, 4.10). The relationship between the currently treating BPD clients variable and treatment and group scores was also analyzed and no relationship was found (See Appendix I, Table 4.11).

The relationship between participants' experience treating BPD individuals and the dependent variables was

found using the Pearson correlation coefficient. The relationship between experience and treating BPD individuals was found to have a statistically significant weak inverse relationship with the dependent variable. This relationship suggests a correlation between the experiences of clinicians treating borderline individuals, the formation of attitudes and the development of knowledge about BPD. Table 4.4 describes the relationship between experience treating BPD and the dependent variables.

Table 4.4

Correlation between experience treating BPD and RAAQ scores

	Pretest	Postest	F/U
Pearson Correlation	-.298*	-.011	.004
Significance (2-Tailed)	.021	.932	.977
N	60	60	60

*Correlation is significant at the .001 level (2-tailed)

It was found that experience with treating BPD was related to lower pretest scores on the RAAQ than with those who had not had experience treating BPD. In fact, the only demographic variable of significance in this study was the experience of the participants in treating individuals

diagnosed with BPD. The variables of age, ethnicity, years in practice, gender, sources of knowledge and feelings about BPD and whether or not participants were currently treating borderline individuals did not have an impact on the scores on the RAAQ. Orientation to treatment was not evaluated.

Summary

In this chapter, the results and analysis of this study were presented. A comparison of the demographic variables revealed that participants in the treatment and control groups were similar in their age, gender, ethnicity, experience with borderline clients, basis for knowledge and feelings about BPD and in their theoretical orientation.

An analysis of the research questions revealed that the effects of treatment were significant with regard to the variables of attitudes toward and knowledge of BPD, based on the analysis of the pretest, posttest and follow-up test scores using the Revised Attitude Assessment Questionnaire.

An analysis of the relationship between the demographic and dependent variables found that the only significant

demographic variable was that of the participants' experience with treating individuals diagnosed with BPD.

CHAPTER FIVE

Discussion, Limitations, and Recommendations

The purpose of this research was to test the hypothesis that clinicians exposed to an educational intervention containing information about Dialectical Behavior Therapy would improve their attitude toward and willingness to treat individuals diagnosed with borderline personality disorder. This study also hypothesized that certain methods must be utilized to alter the attitudes of clinicians during the educational intervention. The research used a self-report scale to measure change following the intervention. Data were collected on 60 adults working as Master's Level Mental Health counselors.

The results of the study are discussed in the following manner: a) summary of findings regarding the research questions, b) description of limitations, c) review of implications and significance of the study and d) recommendations for future study.

Summary of Findings

Research Question

The question proposed as the focus of this research

was: Will a 4-hour workshop on the topic of Dialectical Behavior Therapy improve the attitude of subjects toward clients diagnosed with BPD?

The results of this research confirm that exposure to information about new and effective approaches to the treatment of BPD will improve the attitudes of subjects' participating in a 4-hour workshop on the topic of Dialectical Behavior Therapy.

This positive change in the attitudes of participants was reflected in the increase in the mean score on the RAAQ from the time of the first administration until the administration following the workshop.

Clinicians participating in this experiment were given additional knowledge about the positive impact of DBT on individuals with the diagnosis of BPD and a new perspective on the etiology of the problem. In response to this new information, the participating clinicians appear to be more hopeful about the results of providing treatment, more confident in their own efficacy as therapists and thus more willing to consider providing services for borderline individuals.

This research confirms that knowledge about Dialectical Behavior Therapy will positively impact the

beliefs of clinicians regarding BPD. Consequently, this change will produce an improvement in attitudes toward borderline individuals and increase the likelihood that the clinician will be willing to be involved in the treatment process. This study did not attempt to address the questions of whether other types of knowledge about cognitive therapies for treatment of BPD would produce the same results. The control group was given no intervention, not an alternative intervention. It was hypothesized that Dialectical Behavior Therapy would be effective based on the empirical data regarding its effectiveness. DBT is also comprehensive in its prescription for change, suggested therapeutic skills and behavior and model for providing support and consultation to prevent counselor burnout.

The study found that the clinicians involved in the experiment were likely to view borderline individuals as being difficult to treat and with a limited chance for improvement. This was confirmed by responses noted on the pre-test questionnaire. These responses were typical of those found among clinicians noted in the literature of Millon (1996), Linehan (1993) and McIntosh (1998). The study further suggested that, given certain conditions for

change, the attitudes toward BPD would improve. This change in attitude is reflected in the increase of the mean score on the RAAQ from pre-test to post-test administration for the treatment group. The significance of this change is confirmed by the lack of change reflected in the control group scores on the RAAQ from pre- to post-test administration.

The only similar study examining clinicians' attitudes (McIntosh, 1998) suggested a possible correlation between beliefs about BPD and attitudes toward treating borderline patients. McIntosh concluded that the one belief related to discomfort on the part of the clinicians was that BPD clients had fixed character traits. McIntosh also concluded that the belief that there was no possibility of change as a result of therapy was directly related to the willingness of clinicians to provide therapy to BPD individuals. Thus, knowledge regarding the possibility of change in borderline behavior would positively impact the beliefs of clinicians.

The possibility of attitude change in response to new information was suggested by Linehan (1993) regarding treatment of BPD. Linehan's stated goal in the development of DBT was to present a theory that would be

"scientifically sound and nonjudgemental and nonpejorative in tone" (p. 18). According to Linehan, such knowledge would lead to the implementation of effective treatment techniques as well as a compassionate attitude on the part of clinicians.

The change in attitude found in the subjects in this study if consistent with the findings revealed in the work of Eagly and Chakin (1993) regarding conditions for change. The information presented in the workshop focused on the possibility of producing positive change in individuals diagnosed with BPD. The workshop focused on the disorder as treatable and presented evidence of actual change that had occurred.

Eagly and Chakin's findings revealed that recipients of new information or evidence may form new beliefs about an object, that people are more likely to form favorable attitudes toward stimuli associated with satisfaction of their own needs. They also found that the salience, relevance and reliability of a message affects the process of attitude change. Additionally, they found that experts who communicate the message provide greater incentive for acceptance of their recommendations.

Most recently, empirical studies by Seligman (1998)

involving freshman students at the University of Pennsylavania, demonstrated that a change in pessimistic attitudes to more optimistic ones was possible. The change in attitude was measured by Seligman utilizing an Optimism Questionnaire. Seligman's study revealed that the impact of a 16-hour training program on topics such as stress management was sufficient to produce a change in attitude.

The majority of subjects in both the treatment and control groups in this study were female, Caucasian, between the ages of 31 and 40. Most of the participants had been in practice between 3 and 10 years and had developed feelings about BPD clients as a result of contact with clients. They had gained knowledge primarily through continuing education. Approximately half were currently treating BPD clients. They preferred either brief, solution-focused or an eclectic approach to therapy.

The percentage of women in the sample is typical of the gender representation in the field of mental health counseling. The fact that the ethnicity of the sample was overwhelmingly Caucasian, however, makes meaningful interpretation of the role of ethnicity impossible.

Analysis of the demographic variables revealed that only experience with borderline individuals had significant

impact on attitudes and knowledge scores on the RAAQ for both the treatment and control groups.

This finding is consistent with the studies of Millon (1996), Linehan (1995) and McIntosh (1998) concerning the relationship between the experience of clinicians attempting to treat borderline individuals and the resulting attitudes of those clinicians.

It is difficult to determine if the years in practice, ages, theoretical orientations and source of feelings and knowledge about BPD is typical of mental health professionals, given the limited literature relating to studies of this nature and specific reference to demographic variables of mental health professionals.

Subjects in this study are similar in educational background to those included in the study conducted by McIntosh (1988). McIntosh surveyed 126 licensed clinical Master's level social workers in Los Angeles county. She describes the sample as being "a seemingly good cross-section (p. 35). In this study, subjects age, years of practice, and sex were reported. The cultural background of the clinicians in the study was not investigated. Empirical investigations of desired therapeutic attributes was conducted by Carl Rogers (1957), who utilized graduate

students in psychology. Seligman's (1998) studies of possible attitude changes from pessimism to optimism were conducted with freshman students at the University of Pennsylvania.

The findings of the research questions supported the thesis of the study. It was theorized that a 4-hour workshop, under the right conditions, could increase subjects level of knowledge and understanding of the etiology and effective treatment approaches for use in treatment of individuals diagnosed with BPD. It was postulated that an increase in knowledge about effective approaches to treatment BPD would also result in a change of attitude, from a negative attitude and unwillingness to be involved in the treatment of BPD to a more positive and "optimistic" attitude toward being involved in the treatment of BPD individuals.

Limitations of Study

Several limitations were apparent in this study. The major limitation was related to an attempt to measure two variables (knowledge and attitudes) with one instrument. The results of the study supported revealed that the RAAQ was an effective measure for attitude only. An objective

measure of knowledge would have been a helpful addition to the research.

The choice of instruments and limited pilot testing represent other major limitations. There is insufficient reliability data on either the original or the revised Attitude Assessment Questionnaire being used as the instrument. This questionnaire has been utilized on only one occasion, in a Master's level dissertation as part of a survey research design.

The use of the Likert scale in the RAAQ also presents the following areas of limitation (Babbie,1999):

1. The Likert scale is in matrix question format, which can foster a response set among some respondents.

2. The phrasing of the questions may have encouraged a biased response.

3. Social desirability may have been a factor, given the desire of respondents to present themselves in a favorable light.

4. The appearance of the initial questions may affect the answers given to later questions.

In addition, there is a possibility of test/retest effect resulting from the repeated administration of the Revised AAQ as a pre/post and follow-up instrument.

Additionally, there are limitations of instruments involving self-report. Observation by the researcher and third party validation would contribute to the strength of this study.

Other limitations are related to the sample. Although the sample size was adequate, it may not have been sufficient to determine the impact of intervening variables such as age, gender, orientation, years in the field, etc. There is a question as the generalizability of the outcome, given the primarily Caucasion, female composition of the group.

Finally, the study did not provide information regarding the durability of the change in attitude beyond the 30-day follow-up measure. The question of longer-term durability of attitude change, based on a 4-hour educational experience was not addressed.

Implications and Significance

In this study, one primary research question was identified. The theoretical foundation of the study was based on Linehan's (1993) model for treatment of BPD and implications regarding the impact of new information on existing clinical attitudes. The research question addressed the issue of whether or not the proposed

intervention will alter attitudes toward BPD individuals on the part of participants in a four-hour workshop.

As hypothesized, clinicians initially reported negative attitudes toward BPD patients and a limited willingness to be involved in the treatment. The study also revealed that the contents of the workshop describing Linehan's (1993) model for treatment of BPD (DBT) proved to be a powerfully persuasive message that positively impacted the initial attitudes of the clinicians participating in this research. The belief that one cannot make a difference in the life of a patient appears to profoundly impact the willingness of clinicians to be involved with a particular group. McIntosh (1998) also concluded that the comfort level of clinicians in treating BPD may be a result of their perception of the potential success of their efforts.

This conclusion is consistent with Bandura's (1977)and Seligman's (1998) findings regarding the role of self-efficacy and optimism. Both found that people are more likely to engage in or attempt certain behaviors when they believe they are capable of executing those behaviors successfully, that is, when they have high self-efficacy. Self-efficacy and optimism are also factors in whether or

not people persist in the attempted behavior in spite of failure or setbacks.

While the literature review revealed an understanding that the working relationship between the patient and therapist is an essential part of any psychotherapy, few specific guidelines exist for this component of treatment. This is particularly true for newer approaches to treatment utilizing cognitive and behavioral methods.

There is clear evidence from the literature to support the conclusion that the therapeutic relationship strongly influences treatment results. Clearly, technical and interpersonal factors interact in forming a treatment alliance (Wright & Davis, 1994). The ability to understand the perspective of the patient is identified as a critical component in assisting therapists to optimize the therapeutic relationship.

The focus of therapeutic training has been to provide knowledge regarding psychiatric disorders and treatment approaches. Concern about the training of clinicians was first introduced by Carl Rogers (1957). Rogers suggested that academic training involves learning "above the neck" (p. 249). Clinicians then are forced to learn when dealing with clients in the real world that feelings are the most

important part of living. The tradition of training, Rogers suggests, requires that clinicians are never given the opportunity to integrate these two aspects of human life. The facilitation of learning, Rogers states, requires that the "whole person" be incorporated into the process.

Wright and Davis (1994) conclude that the examination of beliefs, strategies and patterns in the therapeutic relationship can assist the clinician in managing each patient's unique expectations of the treatment process. They also suggest that training programs for therapists, particularly those practicing cognitive-behavioral therapy, should include "intense supervision on relationship issues" (p.42). The relationship aspects of therapy and the clinician's own beliefs and attitudes should receive as much attention as learning how to implement specific techniques of therapy. The ongoing education of clinicians could greatly benefit from effort to learn how our own personality influences our attempts to form collaborative treatment relationships.

Recommendations for Future Study

Based on the results of this research, additional research might focus on educational strategies to address the needs of clinicians in learning the skills required to

effectively establish a therapeutic relationship.

Another area of possible study might be the design of an instrument to more effectively measure attitudes and beliefs of clinicians for use as a pre and post-test measure.

Additionally, it is recommended that workshops similar to the one used in this study be offered, using larger and more varied samples of participants to address the generalizability of the findings of this research. The offering of such expanded educational opportunities would contribute to the development of a method to assist clinicians who strive to be more fully attuned to the requirements of difficult to treat patients, in particular, those diagnosed with Borderline Personality Disorder.

Conclusions and Summary

The present study examined the relationship between knowledge about treatment of borderline personality disorder and the attitudes of clinicians toward BPD and willingness to be involved in the treatment process. The sample consisted of Master's level clinicians who were staff of a Community Mental Health Agency. The participants were primarily female and Caucasian. The majority of participants in the study (n=60) had experienced

therapeutic contact with an individual meeting the diagnostic criteria for BPD.

A one-way Anova revealed a statistically significant relationship between the pretest and posttest administrations to the treatment group of the Revised Attitude Assessment Questionnaire, measuring subjects' attitudes toward and knowledge about Borderline Personality Disorder. The pre-test, post-test and follow-up scores for the control group did not show significant changes from the first administration of the instrument to the second or to the third.

Finally, the use of an instrument that had not been validated prior to this study was a major limitation and most likely had a strong influence on the results of the study.

Future studies would address educational strategies for larger and more varied samples of participants in order to further extend the significance of this study. Future studies would also would also provide longer-term follow-up to determine if additional knowledge produces change that is sustained for a period greater than one month.

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Appendix A

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

1.) Name/(Identifier)_____

2.) Sex: _____Male _____Female

3) Age:

4) Ethnicity:

____Caucasian _____African American _____ Hispanic

____Asian American _____Native American _____ Other

5)Number of years in practice:

_____0-3 years _____ 3-5 years _____6-10 years

_____11-15 years _____16-20 years _____over 20

6) My feelings about BPD have been most influenced by:

_____Client contact _____Colleagues _____Formal education

_____Continuing education, seminars, etc.

7)My knowledge about BPD has been most influenced by:

_____Client contact _____Colleagues _____Formal education

_____Continuing education, seminars, etc.

8)I have experience treating patients with BPD

_____Yes _____No

9)My theoretical orientation is_____

Appendix B

Revised Attitude Assessment Questionnaire

REVISED ATTITUDE ASSESSMENT QUESTIONNAIRE

Please read each statement below. Using the scale, circle the number that best represents your response:

1= Strong Disagree 2= Disagree 3=Not Sure 4= Agree 5=Strong Agree

	SD	D	NS	A	SA
1. I believe that treating clients with BPD could be rewarding	1	2	3	4	5
2. I would choose to work with clients with BPD over those with most other disorders	1	2	3	4	5
3. I prefer to work with clients who have BPD	1	2	3	4	5
4. I feel fulfilled working with clients with BPD	1	2	3	4	5
5. Working with clients with BPD is enjoyable.	1	2	3	4	5
6. I am comfortable working with BPD clients.	1	2	3	4	5
7. I find working with BPD clients a welcome challenge.	1	2	3	4	5
8. If given a choice, I would accept BPD clients in my practice.	1	2	3	4	5
9. Clients with BPD can improve with intensive group therapy.	1	2	3	4	5
10. One of the primary goals in treating BPD clients is to address suicidal & para-suicidal behaviors.	1	2	3	4	5
11. Clients with BPD have difficulty with impulse control.	1	2	3	4	5
12. Client with BPD generally have a poor prognosis.	1	2	3	4	5
13. The etiology of BPD is primarily bio/social.	1	2	3	4	5
14. Traditional forms of psychotherapy rarely benefit borderline clients.	1	2	3	4	5
15. Clients with BPD respond well to an empathetic,	1	2	3	4	5
16. Clients with BPD can benefit from a skills-training	1	2	3	4	5

Appendix C

Workshop Schedule

NEW APPROACHES TO THE TREATMENT OF BORDERLINE PERSONALITY DISORDER: A 1/2 Day Workshop for Mental Health Professionals

Suggested Reading: *Dialectical Behavior Therapy*, Marcia Linehan, Ph.D.

Workshop Schedule

Opening: Introductions, completion of demographic information and Attitude Assessment Questionnaire

Session 1: Understanding Borderline Personality Disorder-(2 hours)

Objectives: To achieve a new understanding of the etiology of BPD and Dialectical Philosophy and apply this understanding to our own experiences with BPD.

Activities:

- Discussion of experiences with treatment of BPD patients (20 min.)
- Presentation of Linehan's biosocial theory of BPD (lecture/discussion)(20 min.)
- Dr. Linehan's Video entitled 'UNDERSTANDING BPD' (45 min.)
- Discussion/Reactions to Video (15 min.)
- Experiential Activity: Completion of Behavioral Chain Analysis (20 min.)

Break (10 min.)

Session II: (2 Hours)

Obectives: To understand DBT functions, applications for treatment and modes of therapy.

Activities:

- Dialectical Behavior Therapy/Skills Training (lecture) (30 min.)
- Dr. Linehan's Video entitled "TREATING BPD" (45 min)
- Dealing with para-suicidal behavior (Discussion) (15 min)
- Demonstration/Role play (Responding to a crisis call utilizing Dialectical Behavior Therapy) (30 min.)

Closing: Final comments/questions/completion of Attitude Assessment Questionnaire.

Appendix D

Workshop Handout #1

APPLICATION OF DIALECTICAL PHILOSOPHY

A. ASSUMPTIONS ABOUT THE NATURE OF REALITY

1. Holistic, connected, and in relationship
2. Complex, oppositional, and in polarity
3. Change is continual

B. FOUNDATION OF THE BIOSOCIAL ETIOLOGY

1. Transactional development and maintenance
2. Systemic disorder

C. TREATMENT STRATEGIES

1. Balance of acceptance vs. change
2. Search for "what is left out"
3. Emphasis on speed, movement, flow

D. TREATMENT GOALS

1. Emotion regulation
2. Interpersonal effectiveness

   vs.

3. Mindfulness
4. Distress tolerance

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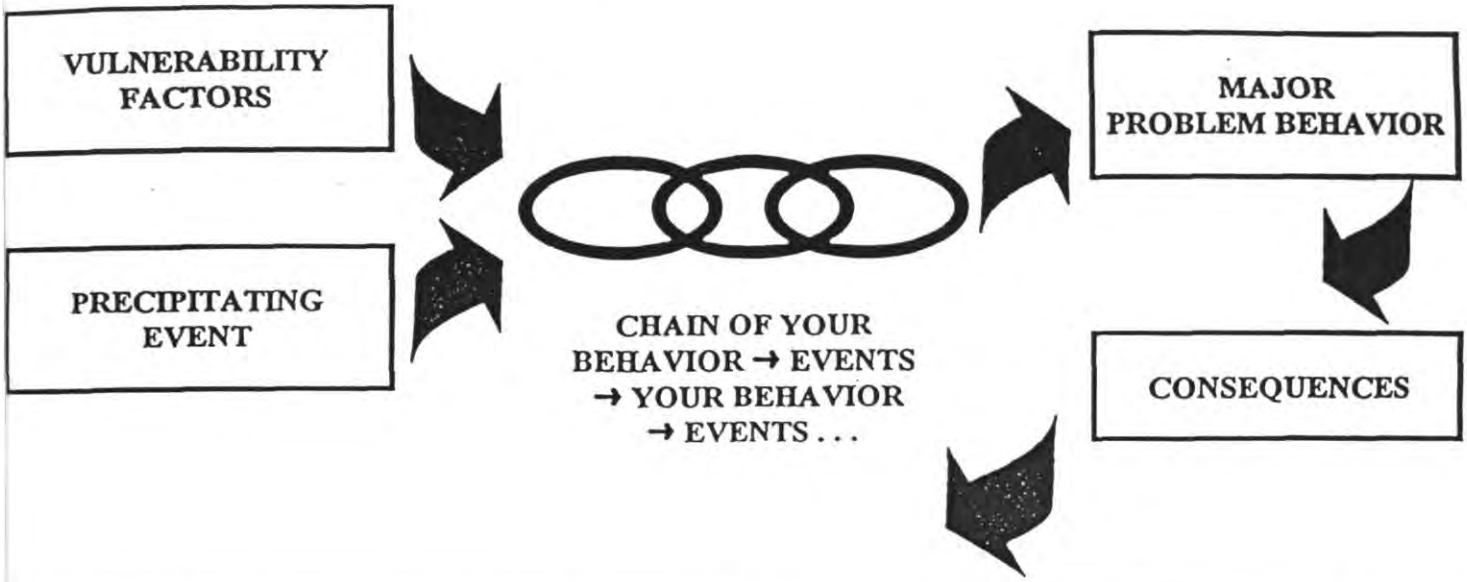
Appendix E

Workshop Handout #2

Behavioral Chain Analysis of Problem Behavior: Page 1

ne:_____Date Filled Out:_____



Vulnerability Factors (Context of Self and Environment) Start Date: ____/____/____

Precipitating Event in the Environment Start Date: ____/____/____

Major Problem Behavior Start Date: ____/____/____Time:_____Place_____

Consequence in the Environment and Yourself

Guidelines for DBT
Behavioral Chain Analysis of Problem Behavior: Page 1

1. **Describe the specific PROBLEM BEHAVIOR** - i.e., throwing a chair, cutting, hearing voices, dissociating, not coming to a therapy appointment, etc. (Behaviors that are targeted in the treatment plan, or diary card.)

   A. Be very specific and detailed. No vague terms.

   B. Identify exactly what you did, said, thought, or felt (if feelings are the targeted problem behavior).

   C. Describe the intensity of the behavior and other characteristics of the behavior that are important.

   D. Describe problem behavior in enough detail that an actor in a play or movie could recreate the behavior exactly.

2. **Describe the specific PRECIPITATING EVENT** that started the whole chain of behavior.

   A. Start with the environmental event that started the chain. Always start with some event in your environment, even if it doesn't seem to you that the environmental event "caused" the problem behavior. Possible questions to get at this are:

      1. What exact event precipitated the start of the chain reaction?
      2. When did the sequence of events that led to the problem behavior begin? When did the problem start?
      3. What was going on the moment the problem started?
      4. What were you doing, thinking, feeling, imagining at that time?
      5. Why did the problem behavior happen on that day instead of the day before.

3. **Describe in general VULNERABILITY FACTORS** happening before the precipitating event. What factors or events made you more vulnerable to a problematic chain? Areas to examine are:

   A. Physical illness; unbalanced eating or sleeping; injury

   B. Use of drugs or alcohol; misuse of prescription drugs

   C. Stressful events in the environment (either positive or negative)

   D. Intense emotions, such as sadness, anger, fear, loneliness

   E. Previous behaviors of your own that you found stressful

Guidelines for
Behavioral Chain Analysis of Problem Behavior: Page 2

4. **Describe in excruciating detail THE CHAIN OF EVENTS** that led up to the problem behavior.

   A. What next? Imagine that your problem behavior is chained to the precipitating event in the environment. How long is the chain? Where does it go? What are the links? Write out all **links** in the chain of events, no matter how small. Be very specific, as if you are writing a script for a play.

      1. What exact thought (or belief), feeling, or action followed the precipitating event? What thought, feeling, or action followed that? What next? What next? etc.
      2. Look at each link in the chain after you write it. Was there another thought, feeling, or action that could have occurred? Could someone else have thought, felt, or acted differently at that point? If so, explain how that specific thought, feeling, or action came to be.
      3. For each link in the chain, ask is there a smaller link I could describe.

5. **What are the CONSEQUENCES** of this behavior? Be specific.

      1. How did other people react immediately and later?
      2. How did you feel immediately following the behavior? later?
      3. What effect did the behavior have on you and your environment?

6. **Describe in detail different SOLUTIONS** to the problem.

   A. Go back to the chain of your behaviors following the prompting event.? Circle each point or link where if you had done something different you would have avoided the problem behavior.

   B. What could you have done differently at each link in the chain of events to avoid the problem behavior? What coping behaviors or skillful behaviors could you have used?

7. **Describe in detail PREVENTION STRATEGY** for how you could have kept the chain from starting by reducing your vulnerability to the chain.

8. **Describe what you are going to do to REPAIR** important or significant consequences of the problem behavior ?

Behavioral Chain Analysis of Problem Behavior: Last Page

Name:_____ Date Filled Out:_____

Different Solutions

Prevention Strategies for the Future

Plan for Repair (Correction and Over-Correction)

Comments

Appendix F

Original Questionnaire

QUESTIONNAIRE

In this first section you will be asked some basic questions regarding diagnosis of Borderline Personality Disorder (BPD).
(Check all of the following criteria which you believe to be definite indicators for a diagnosis of Borderline Personality Disorder)

____1. Instability in interpersonal behavior, mood and self-image.
____2. Anti social behavior (truancy, delinquency, vandalism and initiation of fights).
____3. Interference with social and occupational functioning.
____4. Difficulty expressing anger.
____5. Paranoid delusions.
____6. Presence of self damaging acts.
____7. Extensive psychotic episodes.
____8. Manipulation (constantly using others for one's own ends).
____9. Accompanied by features of other personality disorders.
____10. Use of primitive defenses (splitting and projective identification).

In this next section you will be asked questions regarding your level of comfort in working with clients with Borderline Personality Disorder (BPD).
(Circle the answer which most closely matches your feelings about the following statements)

SD=STRONGLY DISAGREE
D=DISAGREE
NS=NOT SURE
A=AGREE
SA=STRONGLY AGREE

11. I believe that treating clients with BPD can be very rewarding.	SD	D	NS	A	SA
12. I would choose to work with clients with BPD above those with most other disorders.	SD	D	NS	A	SA
13. I prefer not to work with clients who have BPD.	SD	D	NS	A	SA
14. I feel unfulfilled working with clients with BPD.	SD	D	NS	A	SA
15. I would choose to work with clients with most any other disorder before working with those with BPD.	SD	D	NS	A	SA
16. Treating a client with BPD makes me uncomfortable.	SD	D	NS	A	SA
17. Working with clients with BPD is enjoyable.	SD	D	NS	A	SA
18. I am very comfortable working with clients with BPD.	SD	D	NS	A	SA
19. I find working with clients with BPD a welcome challenge.	SD	D	NS	A	SA
20. If given a choice, I would not accept clients with BPD in my practice.	SD	D	NS	A	SA

This next section asks for your opinions regarding aspects of Borderline Personality Disorder. (Circle the answer that most closely matches your feelings regarding each statement)

21. Clients with BPD can improve greatly with individual psychotherapy.	SD	D	NS	A	SA
22. The primary goal in treating clients with BPD is to promote acceptable behavior.	SD	D	NS	A	SA
23. Clients with BPD have an inability to control aggressive drives.	SD	D	NS	A	SA
24. Clients with BPD generally have a poor prognosis.	SD	D	NS	A	SA
25. The etiology of BPD is primarily genetic.	SD	D	NS	A	SA
26. Lying is a common behavior of clients with BPD.	SD	D	NS	A	SA

SD=STRONGLY DISAGREE
D=DISAGREE
NS=NOT SURE
A=AGREE
SA=STRONGLY AGREE

27. The therapeutic goal in working with clients with BPD is to facilitate the development of internal psychic structure._____ SD D NS A SA
28. Most clients with BPD are physically aggressive towards others._____ SD D NS A SA
29. The causes of BPD are largely environmental._____ SD D NS A SA
30. The ways that clients with BPD relate to others represent fixed character traits._____ SD D NS A SA
31. Treatment with psychotherapy rarely benefits clients with BPD.___ SD D NS A SA
32. Clients with BPD respond therapeutically to an empathic atmosphere._____ SD D NS A SA
33. Clients with BPD have the ability to benefit from insight._____ SD D NS A SA

This section will ask for information about your clients.
(Write in a number where applicable)

34. Total number of clients you have seen since you obtained your L.C.S.W.
(Check number that applies)

___1 - 10
___11 - 25
___26 - 50
___51 - 100
___Over 100

35. Percentage of total clients you have treated since you obtained your L.C.S.W. who have had BPD.

_____% (Write percentage in)

36. Total number of clients with BPD that you are currently treating in your practice is_____.

37. What percentage of your current caseload falls into the following categories?
(Write the percentage next to the group)

____WHITE
____BLACK
____ASIAN
____HISPANIC
____UNKNOWN

38. What percentage of your current caseload falls into the following ages?
(Write the percentage next to each group)

____UNDER 19
____19-29
____30-39
____40-49
____50-59
____OVER 59

39. What percentage of your current caseload falls into the following household income levels? (Write the percentages next to each group)

____UNDER $10,000
____$10,000-$20,000
____$20,001-$30,000
____$30,001-$40,000
____$40,001-$60,000
____OVER $60,000

(Turn Page Over)

Appendix G

Consent Form

STANDARD CONSENT FORM

UNIVERSITY OF SAN FRANCISCO

CONSENT TO BE A RESEARCH SUBJECT

A. PURPOSE AND BACKGROUND

Suzanne Fraser, in the Counseling Psychology Department of the University of San Francisco, is doing a study of the effect of an educational intervention on clinician's attitudes toward Borderline Personality Disorder, which I am being asked to participate in.

B. PROCEDURES

If I agree to be in the study, the following will occur:

1. I will participate in a four hour workshop

2. I will be asked to complete a pre-test/post-test and follow-up questionnaire consisting of 16 questions.

This will take place at the offices of East Valley Psychological Center and will take about 4 hours.

C. RISKS/DISCOMFORTS

1. I will need to be in a room for a 4 hour period.

2. Study records will be kept as confidential as possible. No individual identities will be used in any reports or publications resulting from this study. Study information will be coded and kept in a locked file at all times. Only study personnel will have access to the files.

D. BENEFITS

In conjunction with my participation in this study, I will fulfill my agency's requirement to complete in-service training.

E. ALTERNATIVES

I am free to choose not to participate in this study.

F. COSTS

There will be no costs to me as a result of taking part in this study.

G. REIMBURSEMENT

There will be no reimbursement for my partcipation in this study.

H. QUESTIONS

I have spoken with Suzanne Fraser about this study and have had my questions answered. If I have any further questions, I may call her.

If I have any questions or comments about participation in this study, I should first talk with the investigator. If for some reason, I do not wish to do this, I may contact IRBPHS, which is concerned with the protection of volunteers in research project. I may reach the IRBPHS office between 8:00 AM and 5:00 PM, Monday – Friday, by calling (415) 422-2416, or by writing to IRBPHS, University of San Francisco, 2130 Fulton ST., San Francisco, CA 94117-1080.

I. CONSENT

I have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point . My decision as to whether or not to participate in this study will have no influence on my present or future status as an employee.

Date Subject's Signature

Person Obtaining Consent

Appendix H

Chapter III Tables

Table 3.1

Frequency and percentage for Demographics by Groups

	Treatment		Control	
Variable	*f*	%	*f*	%
Sex				
Male	8	27	8	27
Female	22	73	22	73
Age (years)				
Under 25	0	0	0	0
25-30	4	13	4	13
31-35	10	30	10	33
36-40	4	13	7	20
41-45	4	13	5	13
46-50	4	13	4	13
51-60	3	10	5	13
over 60	0	0	0	0
Ethnicity				
Asian	1	1	0	0
African American	5	16	2	10
Hispanic	3	3	3	10
Caucasian	21	70	25	80
Years in Practice				
< 1 year	0	0	0	0
1-2	4	13	4	13
3-5	10	33	10	33
6-10	9	30	3	43
11-15	5	16	0	7
16-20	2	6	0	0
over 21 years	0	0	0	0
Feelings influenced by				
Client contact	19	63	21	70
Continuing Ed	1	3.5	0	0
Colleagues	9	30	9	30
Formal Ed	1	35	0	0
Knowledge gained by				
Client contact	8	17	0	15
Continuing ed	10	43	23	38
Colleagues	0	0	0	0
Formal Ed	12	40	7	47
Experience with BPD				
Yes	24	80	24	77
No	6	20	6	23
Currently Treating				
Yes	16	60	15	50
No	14	40	15	50
Treatment Orientation				
Brief,	10	30	12	40
Family systems	3	27	0	30
Cognitive/behavior	4	10	2	7
Eclectic	8	11	2	11

Table 3.2

A Comparison of the Original and Revised AAQ Questions

Original	Revised
Question #11 I believe that treating clients with BPD could be rewarding very rewarding."	Question #1 I believe that treating clients with BPD can be
Question #13 Clients with BPD have an inability to control impulses	Question #11 Clients with BPD have difficulty with impulse control
Question # 4 I feel unfulfilled working With clients with BPD	Question #4 I feel fulfilled working with clients with BPD
Question #6 Treating a client with BPD me uncomfortable	Question #6 I am comfortable working with clients with BPD
Question #20 If given a choice, I would would not accept clients with BPD in in my practice.	Question #8 If given a choice, I accept clients with BPD my practice.
Question #21 Clients with BPD can improve greatly with individual group psychotherapy.	Question #9 Clients with BPD can improve with intensive group therapy
Question #22 The primary goal in treating clients with BPD is to promote acceptable behavior.	Question #10 One of the primary goals in treating BPD clients to address suicidal

Table 3.3

Cronbach's Coefficient Alphas for Pre, Posttest and Follow-Up Administration of the RAAQ

Scale	Cronbach's Alpha
Pretest	.33
Posttest	.86
Follow-Up	.86

Appendix I

Chapter IV Tables

Table 4.1

Comparison of Pre-Posttest and Follow-up Mean Scores For Treatment and Control Groups

	Pretest	Posttest	Follow-Up
Treatment Group	45.067	57.90	58.00
Standard Dev.	3.45	2.17	2.26
Control Group	46.17	46.17	46.03
Standard Dev.	2.80	2.80	2.82

Table 4.2

Two-Way Analysis of Variance Results for Pre-Posttest and Follow-Up Scores by Group

Source	ss	df	F	Eta-Square
		Between Group		
Group	2553.80	1	132.49	.70
Error	1117.98	1		
		Within Group		
Pre,Post & F/U	1642.68	2	476.64	.89
Time by Group	1200.00	2	486.73	.89
Error	199.89	2		

*Statistically significant at the .05 level

Table 4.3

Frequency Distribution of 5 Most Common Test Scores

	Pretest	*f*	Posttest	*f*	Followup	*f*
			Treatment Group			
1st	47	4	57	7	58	8
2nd	47	4	58	6	59	4
3rd	46	4	60	5	57	4
4th	44	3	56	4	60	3
5th	42	3	59	3	54	3
			Control Group			
1st	49	6	49	6	46	7
2nd	46	6	46	6	49	5
3rd	47	4	47	4	48	3
4th	45	3	45	3	47	3
5th	48	2	48	2	45	2

Table 4.4

Correlation Between Experience Treating BPD and RAAQ Scores

	Pretest	Postest	F/U
Pearson Correlation	-.298*	-.011	.004
Significance (2-Tailed)	.021	.932	.977
N	60	60	60

*Correlation is significant at the .001 level (2-tailed)

Table 4.5

Analysis of Correlation of Ethnicity

	N	Mean	SD	SE	F	Sig
			Pretest			
White	45	45.73	3.24	.47	.604	.616
Afr.Am.	8	45.00	3.78	1.34		
Hispanic	6	46.17	2.93	1.20		
Asian Am.	1	42.00	7.91	2.80		
Hispanic	6	52.00	6.00	2.45		
Asian Am.	1	56.00				
			Posttest			
White	45	51.69	6.35	.96	.266	.850
Afr.Am.	8	53.50	7.91	2.80		
Hispanic	6	52.00	6.00	2.45		
Asian Am.	1	56.00				
			Follow-Up			
White	45	51.69	6.47	.9634	.266	.850
Afr. Am.	8	53.50	7.91	2.80		
Hispanic	6	52.00	6.00	2.45		
Asian Am.	1	56.00				

Table 4.6

Analysis of Correlation of Age

	Pretest	Posttest	Follow-Up
Age			
Pearson	-.167	-.087	-.082
Signif.	.204	.509	.534
N	60	60	60

Table 4.7

Analysis of Correlation of Gender: Treatment Group

	N	Mean	SD	SE	F	Sig
			Pretest			
Male	8	44.37	2.67	.9437	.429	.518
Female	22	45.32	3.72	.7933		
			Postest			
Female	22	45.32	3.72	.7933	.6305	
Male	8	57.00	1.69	.5976	1.935	.175
Female	22	58.23	2.27	.4832		
			Follow-Up			
Male	8	57.3750	1.99	.7055	.830	.370
Female	22	58.2273	2.35	.5098		

Table 4.8

Analysis of Correlation of Gender: Control Group

	N	Mean	SD	SE	F	Sig.
			Pretest			
Male	6	46.83	2.1370	.8724	.415	.525
Female	24	46.00	2.9635	.605		
			Posttest			
Male	6	46.83	1.14	.8724	.415	.525
Female	24	46.00	2.96	.6049		
			Follow-Up			
Male	6	47.00	2.00	.8165		
Female	24	45.79	2.98	.6079		

Table 4.9

Analysis of Correlation of Sources of Feelings for Treatment Group

	N	Mean	SD	SE	F	Sig
			Pretest			
Client Contact	20	44.65	3.18	.7118	.869	.359
Colleagues	10	45.90	3.98	1.2601		
			Posttest			
Client Contact	20	45.07	2.03	.4547	.790	.382
Colleagues	10	58.40	2.46	.7775		
			Follow-Up			
Client Contact	20	57.80	2.04	.4565		
Colleagues	10	58.40	2.72	.8589		

Table 4.10

Analysis of Correlation of Sources of Feeling of Control Group

	N	Mean	SD	SE	F	Sig
			Pretest			
Client Contact	22	45.86	2.64	.5633	.962	.335
Colleagues	8	47.00	3.25	1.1495		
			Postest			
Client Contact	22	45.86	2.64	.5633	.962	.335
Colleagues	8	47.00	3.25	1.15		
			Follow-Up			
Client Contact	22	45.82	2.6302	.5608	.471	.498
Colleagues	8	46.63	3.4200	1.2092		

Table 4.11

Analysis of Correlation of Currently Treating BPD for Treatment Group

	N	Mean	SD	SE	F	Sig.
			Pretest			
Yes	16	44.38	2.68	.670	1.394	.248
No	14	45.86	4.13	1.10		
			Posttest			
Yes	16	57.75	2.75	.57	.159	.693
No	14	58.07	2.13	.57		
			Follow-Up			
Yes	16	57.87	2.42	.60	.102	.752
No	14	58.14	2.14	.57		

THE UNIVERSITY OF SAN FRANCISCO

Dissertation Abstract

The Impact of Training on the Attitudes of Mental Health Professionals Toward Borderline Personality Disorder

The Research Problem: Individuals diagnosed with Borderline Personality Disorder (BPD) are presenting themselves for treatment at mental health facilities in ever-increasing numbers. Borderline individuals experience extreme problems, are difficult to treat successfully and present major challenges for mental health professionals. Self-injurious acts are the hallmark of patients diagnosed with BPD. Faced with treating borderline clients, clinicians often feel overwhelmed and helpless, thus avoiding involvement with clients diagnosed with this disorder. The purpose of this study is to evaluate the impact of training in Dialectical Behavior Therapy (DBT) on the negative attitudes held by mental health professionals. Procedures and Methods: The research question addressed in this study was: Will a 4-hour workshop increase participants' improve participants' attitude toward BPD clients and increase their willingness to treat BPD clients? This study utilized a 2 x 3 pretest-postest, repeated measures control group design. Participants were Master's level mental health professionals assigned randomly to one of two conditions: a treatment (workshop) group and a control group. Results: The results of the intervention produced a positive change on the Revised Attitude Assessment Questionnaire designed to measure attitudes toward and willingness to treat BPD individuals. Conclusions: The implications of the study results confirm the hypothesis that increased knowledge about the etiology and effective treatment methods

for individuals diagnosed with BPD will alter the attitudes of mental health professionals toward providing treatment.

Suzanne R. Fraser

Dr. Terry Patterson
Chairperson, Dissertation Committee